# Moral problems in the theory and practice of health promotion.

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# MORAL PROBLEMS IN THE THEORY AND PRACTICE OF HEALTH PROMOTION

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**2000**

**Thesis submitted for the degree of Doctor of Philosophy**

**'It is a risky enterprise to have to write of virtue....'**

**(Thomas Keneally, *Schindler's Ark*)**

## ACKNOWLEDGEMENTS

I would like to thank all the people who have supported and helped me during the writing of this thesis and the research it represents:

Alan Cribb, my supervisor, for his wise advice and moral support over a very long period;

The students who allowed me access to their assignment writing on ethics and health promotion;

Pam Schickler of South Bank University for supporting my request for access and for general encouragement;

My colleagues and students at the School of Education, King's College London, who have helped me in the development of many of my ideas about the moral problems of health promotion; and who have made the School a stimulating and fascinating place to work.

Finally, my deepest thanks are to Jane. Without her I would not have been able to complete this thesis. I dedicate it to her and to our two lovely little girls.

## ABSTRACT

This thesis submits the relatively novel field of activity of health promotion, together with its underlying theoretical base, to ethical investigation.

It begins with provisional sketching of what might be understood by 'health promotion', using the writing of a number of notable theorists at work in the British Isles. The history of health promotion (and the closely related traditions of public health and health education) are then charted.

Major dispute and disagreement are identified within these theoretical and historical perspectives. Yet health promotion has been represented as a field unproblematic in a moral sense; or at the very least, capable of robust moral defence and justification. A defence of health promotion as a *prima facie* good is constructed for the purposes of critical examination. In particular, the idea that health promotion is such a good because of its frequent focus on 'empowerment' is subjected to scrutiny.

The perceptions of a number of health promotion practitioners on the moral problems of the field, and how they emerge, are then described and discussed. These perceptions were elicited through a process of textual analysis- examining some of the assignment writing of the practitioners, who were also postgraduate students of health promotion.

A return is then made to moral theory in order to determine the level of help it might offer in understanding and dealing with the field's ethical difficulties. First, the actual and potential contribution of bioethics is discussed. Then health promotion (as an occupational and possibly professional) activity is considered

in relation to arguments as to how it is possible to 'ground' professions in a moral sense.

Finally, the experience of both practitioner participants in the research and the researcher in thinking about the ethical problems of health promotion is considered. 'Markers' for the possible moral reconstruction of the field are laid down. The value of writing as a tool to support reflection on, understanding of and ways of dealing with difficulties is discussed.

# MORAL PROBLEMS IN THE THEORY AND PRACTICE OF HEALTH PROMOTION

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**Chapter Nine- Towards Health Promotion's Moral Reconstruction: Reflecting on Theory and Practice**

## PREFACE

In May 1989, I celebrated my thirtieth birthday. Adapting the poet Brian Patten slightly, it would have been best to have arrived at this age grinning and drunk, dressed in poor clothes and heads full of dragons. Instead, I was completely sober and fighting the inevitable onset of uncomfortable sleep on a transatlantic flight from Boston to London. I was also trying to come to a decision about the future direction of my career.

Until this point, I had taken the notion of a 'career' rather easily and lightly. Several years earlier, I had trained as a Registered General Nurse. For various reasons, I had decided to leave nursing and as they say in the potted biographies of paperback authors, had gone on to do a succession of jobs. These included being a women's magazine 'agony aunt', working on a telephone help line run by a national medical charity and editing specialist holiday guides. They were all fun, but as I coasted along rather light heartedly with these jobs, other parts of my life were taking on a more serious character. If I'd been older and wiser, I would have recognised the jobs themselves as being pretty serious; but I was in my twenties and unable particularly to take life as a difficult business. Now, though, I was married. I had a mortgage. These things, I thought, needed to be accompanied by a 'proper' career.

Several months before reaching 30, I had made what I thought was going to be a temporary move, to working as a health promotion officer with an inner London health authority. My plan was to leave this within about a year and take up a full time law course. Law seemed both tangible and serious. I would be a professional person. It would be easy to explain to people at parties what I did. ('I'm a solicitor' rather than 'I'm an agony aunt, or a health promotion officer', or whatever.) In short, it seemed like the 'proper' career I felt the need of. But as I read more and more law, getting ready for my planned course, I became less and less interested in its technicist

structure and detail. At the same time, health promotion- a job which I thought I could do intuitively (in the same way that I'd done every other job I'd so far had)- presented itself to me as far more complex and interesting than I had ever imagined. To cut a long story short, I ditched the idea of law and carried on with health promotion.

Yet if health promotion was complex and interesting, as I thought it to be, a serious approach to it was required. Believing that one route to seriousness (or at least to appearing more serious) was through academic study, I began a postgraduate diploma in health education course at what was then South Bank Polytechnic, London, in September 1989.

During the first module of the course, I went on a week's placement to the Health Promotion Department in Hull. I enjoyed my time there. Days were an interesting mix: of talking to the friendly and knowledgeable staff; and of 'shadowing' some of them as they went about their work. The primary health care facilitator took me to a local general practice, where plans were finalised for a primary health care 'team workshop'. I went with one of the health promotion officers to the district hospital to discuss plans for a local campaign to promote breast screening with a consultant physician. The head of the Department (who I later realised was a notable figure in the world of specialist health promotion practice) drove me to a school where we talked through ideas for health education curriculum development with the PSHE (personal, social and health education) co-ordinator. I also went with him to a meeting to negotiate further funding for a voluntary group concerned with HIV and AIDS prevention.

And evenings! I spent the evenings enjoying the slightly backwater atmosphere of the city that Philip Larkin describes often in his poems, including 'Here':

'Here domes and statues, spires and cranes cluster

'Beside grain - scattered streets, barge- crowded water,

'And residents from raw estates, brought down

'The dead straight miles by stealing flat - faced trolleys,

'Push through plate - glass swing doors to their desires....'.

Larkin was writing some time before 1964 (the poem appears in 'The Whitsun Weddings', published during that year). By 1989, the city had become de-industrialised; quite a different place to the brash, busy port of 'Here'. Now Hull had a pedestrianised city centre, a flash marina (converted from the old docks) touching the edge of this and quite a number of designer bars. Yet although the 'grain- scattered streets' had disappeared, it was still great fun wandering around the place, not least because this was a bit of an exercise in nostalgia for me. I had spent 1978 to 1981 at the University there, completing a degree in philosophy. (The late 1970s were just about the last gasp of the city and port Larkin had been describing the decade previously. I can remember the Bolivian Consulate, a tatty house on the down at heel Beverley Road.)

At the end of my week, I took the train back to London. On the way- I had to change at Doncaster and I remember there being delays- I read an article photocopied during one of my idler moments at the Health Promotion Department. It was entitled 'Health promotion- caring concern or slick salesmanship?' (WILLIAMS, 1986).

At the time of writing the article, Gill Williams had been lecturing in health education at the former Chelsea College. And in fact she had come to talk to our group at South Bank a couple of weeks before my trip to Hull. As I read, I remembered I had been interested by what she had said at our lecture. (She had been talking about ethics and health promotion; and the philosophical content of her talk had stirred vague memories of my time at university). However, it had only been a mild interest. I

hadn't quite been able to see the connection between ethics - a subject I associated with abstract, possibly dry philosophers such as Peter Geach and Elizabeth Anscombe, two of the 'stars' of the discipline when I had been a philosophy student- and the very practical activity of health promotion with which I was now involved.

But as my delayed train finally quickened its pace and sped through the gathering dark towards London, I became gripped by the article. Those involved in health promotion, she was arguing, were setting themselves up as possessing 'expertise' in health. Quite what gave them grounds to do so, and what expertise in health actually entailed, was often unclear because the health promoters failed to try and make it so. The single understandable version of health promotion Williams had encountered, she wrote, was the 'hard sell' marketing approach developed in South Australia. I have re-read this paper many times since that evening in 1989, and doing so just before writing this, I note again the way in which Williams describes 'hard sell' health promotion:

'Health promotion.... is no different from any other form of "selling"; it requires either a ready market or the means to stimulate one; it requires concentrated efforts by expert communicators in the media and in the health services; and it requires a "market research" approach to evaluation to prove that it works.... This kind of health promotion.... focuses on the same kinds of methods which are available to those who sell other kinds of "goods"....' (WILLIAMS, 1986: 425).

If this is the case, Williams asserts, then we should be entitled to ask of the health promoter the same kinds of questions we would ask any other salesman, namely:

'1. What am I being offered or sold?

'2. Is it necessary/ do I want it?

'3. Does it work/ do what is claimed?

'4. Might it do harm/ could I be worse off?

'5. What's in it for the salesman....?' (WILLIAMS, 1986: 426).

Health promotion, Williams claims, would fare rather badly if it tried to answer most of these apparently reasonable questions. In relation to the first, health promotion offers the means to a desired, ideal end ('more health'), yet there is no evidence to suggest a proven link between health promotion means and health ends (whatever health ends might be understood as). With regard to question two, perhaps it could be assumed that most of us want or need to be healthy. But again with the third question, we are drawn back to the lack of evidence suggesting causal- or even likely- connections between health promotion and eventual better health. In response to question four, there is a real risk that health promotion may produce harm as well as benefit. (Williams uses the example of raising awareness of breast self- examination techniques. For some at least, self - examination will provoke considerable anxiety and tension.) Finally, Williams addresses the fifth question and suggests, in the light of responses to what has previously been asked:

'It is a sad reflection on a "caring profession" that the professionals or "salesmen" appear to be deriving more benefit from the enterprise than are the clients, but there seems to be little evidence available to the contrary at the present time....' (WILLIAMS, 1986: 429).

Reading the paper once again, I can see more weaknesses in it than I remember doing while returning from Hull in 1989. Against a historical perspective, it is clear that to some extent Williams was railing against the new form of words, 'Health Promotion'. In the United Kingdom, many previously titled health **education** departments switching during the mid- 1980s to this new nomenclature. This was largely, it seemed, to give themselves an easy metaphorical lick of new paint while mostly doing what they had always done. Williams is clearly an aficionado of education for

health and did not like what was happening, even if it was just in name only. Moreover, she does not justify her attachment to health education in a particularly robust way; it could be argued that many of the accusations levelled at health promotion apply equally to health education (or at least to certain conceptions of health education). Finally, her reliance on one particular approach to health promotion (the 'hard sell') is a caricatural device inevitably supporting her own arguments; straw men can easily be knocked down.

Despite these weaknesses, nine years later I am still struck by the force of Williams' claims and the extent to which they remain plausible. Despite relatively high levels of attention in recent times to the issue of health promotion's effectiveness, very little is still known about the connections between what it does and actual improvements in health. In my experience, the suggestion that health promotion might actually provoke harm is often met with resistance and unwillingness even to consider this as a possibility. There is even a view, I have found, that health promotion has 'considered ethics' and, finding itself not wanting, can move on with an easy conscience.

My main memory of that journey back to London, though, is of the almost overwhelming excitement from reading the article. I felt excited for two reasons. First, what Williams had written seemed directly relevant to me and to what I was doing. I had just spent the week 'shadowing' people involved in promoting breast screening, schools health promotion, and funding organisations concerned with HIV prevention. When I finished this module of study, I would go back to 'proper' work, where I was to plan and implement a campaign promoting childhood immunisation uptake. Yet where was the justification for this work? What did I actually know about its effects, beneficial or otherwise? More broadly, what did I really know about the purpose of health promotion, and of the department where I worked?

The second reason for being excited was probably even more significant. Nearly a decade before my return trip to Hull, I had finished studying philosophy there. Almost up to this point, I had not only finished studying philosophy; but had also finished studying full stop. For eight years I had avoided academic work, believing that I needed to get on with 'real life' and assuming that study couldn't or shouldn't play any part in this. The Williams article, though, had provided one of the sparks that made me recognise academic study was both enjoyable and valuable. It could indeed help me understand the world (and perhaps philosophy could be of particular help). I'm sure I wasn't fully aware of it as I got off the train at King's Cross station late on that October evening in 1989, but my life was beginning a fundamental change.

I finished the first module of the course and went back to work. I got on with the immunisation campaign. I also started the module assignment, a 2500 word essay. I wrote about an ethical issue or dilemma from my practice. My focus was the difficulties involved in using a 'lifestyle questionnaire' I had developed with some other people in the health promotion department where I worked. We used this questionnaire at 'health fair'- type events to engage people in discussion about their health behaviour- smoking, drinking, diet and so on. The aim was to encourage thinking about health risk and health choices; but it also seemed to me that in trying to identify risk we were undertaking an activity which could be regarded as screening. In the assignment, I argued that it seemed sensible to ask a number of questions about the use of the questionnaire as a kind of health screening: was it of benefit?; was there the chance of it causing harm?; did it respect the individual? These questions were a bit like those asked by Williams of her 'health promotion salesman'. They were also connected to so- called principles of biomedical ethics developed in the United States by Beauchamp and Childress (1994), although up to this time the principles had largely been applied to the moral problems of 'acute' health care.

I can no longer find the assignment I actually submitted, but I do remember concluding there was good reason to believe use of the lifestyle questionnaire did raise moral problems. In particular, it was often (perhaps it was always) impossible to track a definite relationship between health promotion activity and health improvement. How, then, could we be sure that what we were doing was of benefit? And if we weren't sure about benefit, shouldn't we be looking more closely at the potential for harm held by the activity?

My tutor encouraged me to turn the assignment into an article and a conference presentation. The conference to which I presented it was the 1990 annual seminar of the Society of Health Education and Health Promotion Officers (as it was then known), held in April at Warwick University. I am looking at the text of the presentation now and can remember finishing off my talk to the 60 or 70 delegates- who I guessed were mostly health education and health promotion practitioners- gathered in the lecture theatre:

'These.... questions I've asked about screening all raise major worries on its ethical implications. At the very least, these worries should cause the question with which I started- should we be participating in pre- symptomatic screening for coronary heart disease?- to be treated more seriously than might otherwise be allowed....'.

I suggested that while we might be caught between the demands of practice and concerns about its moral implications; understanding and thinking about these implications might actually be positive for what we did. I stopped speaking and sat down.

There was silence. The person chairing the session asked for questions. There was just one. I can't remember it exactly, but it was along these lines: 'You have posed what you consider to be a practice dilemma. We do not have any real choice about

practice in this area- "lifestyle questionnaires" and associated activity are fashionable things and doing them is in part one of the ways in which Health Promotion Departments can become "acceptably visible". What do you propose we should do? Give up on them altogether? Refuse to get involved?'

It was a rhetorical question and I could very easily see its point. Given we had to get involved with things like lifestyle questionnaires, wasn't there something perverse in trying to get people worried about what they were doing?

The conference participants drifted out of the lecture theatre, off to workshops with very practical, useful- sounding titles like 'Management', or 'Marketing', or 'Performance Indicators'. I went back to London. I spent a long time waiting for a taxi to take me to Coventry station. On the train, I sat and worried about the question I had been asked. The certainty I had felt about the relevance and importance of ethics to health promotion arriving at King's Cross on the evening of my 'revelation' had vanished. In its place, as my train from the Midlands approached Euston station on a sunlit Spring afternoon, there was doubt.

In time, the article I had based on my assignment was accepted and published by the Health Education Journal (DUNCAN, 1990). I had by now switched jobs. From working in Inner London, I was managing a small Health Promotion Department, based in a Wiltshire cathedral city but with a mainly rural constituency. I was spending the weeks in Wiltshire and the weekends at home in London until we managed to find somewhere to live closer to my new work. Thoughts on ethics and health promotion were given up to the demands of this temporary period of trying to live in two places at once.

It was early in 1991, about the time of the Gulf War. I remember being woken up one night by the phone ringing. It was my wife, calling to tell me that the allied forces

were bombing Baghdad. I put the phone down, thinking that the world was ending and that I would never see her again.

I was relieved to wake up the following morning, and to find things still in their place. While I was chatting to a colleague over lunch, she remarked, 'Did you see the reply to your piece in the Health Education Journal? I'm not sure he got what you were saying right.'

I went to the hospital library and looked at the latest edition of the Journal. In it there was a letter to the editor, entitled 'Screening':

'Peter Duncan's article in the last *Journal* (HEJ 49/3) should not go unchallenged lest its publication in a respectable journal gives further ammunition to those who argue that resources currently allocated to health promotion would far better be spent on more proven technologies such as cardiac surgery, monitoring equipment, streptokinase and so on.

'Firstly, of course, the evidence that health promotion works is far stronger than Peter Duncan allows.... More importantly, however, I disagree with Duncan's basic proposition that what is going on in cardiovascular prevention clinics is screening: it is not. What is going on is counselling. As Duncan makes clear, screening for cardiovascular disease, among the general population of the UK, would be a very problematical activity. We may of course come across the occasional person with frank disease or gross abnormality who needs further investigation and treatment. But our basic aim should be to chat to everyone about themselves, explore their views and say how we think they can make life more healthy and enjoyable.

'We can say to people: "Hey, have you thought about regular exercise? You'll feel a lot better for it"; or "Look, I've cut down on the salt I use in cooking, and now I can

really taste some flavours I never realised were there: how about you?" All this can be done with full respect for the person's own values and beliefs; and without any fear of psychological damage.

'Let us not forget that moral paralysis is itself culpable if it subverts efforts, based on reasonable judgement, to help people enjoy life to the full, free- as far as possible- from the burden of cardiovascular disease....' (JESSOP, 1991: 52).

The writer was a Director of Public Health, a figure of relative influence, albeit in a neglected area of NHS activity. Yet the more I read the letter, the more I disagreed with it. Jessop claimed the evidence health promotion works was far stronger than I was allowing. But where was the evidence that his 'ethically clean' version of health promotion worked? What he was talking about, branded as 'counselling', seemed to be some kind of strange cross between an agony aunt's advice and a good chat over a pint at the pub. If Jessop was interested in health promotion that worked (for the sake of argument, **effective** health promotion); it was hard to see how his preferred version was in fact likely to be effective, or even measurable. Paying people NHS money to chat seemed an unlikely idea. I was much more prepared to believe that Health Service cash was going to be spent on a version of health promotion along the lines of Williams' 'hard sell'.

I agreed with my colleague that he hadn't got right what I'd been attempting to say. I wasn't trying to supply ammunition to those sceptical about health promotion's effectiveness. My claim was more fundamental: that the conceptual and practical basis of health promotion required examination; and that ethical investigation might form one part of such scrutiny.

Jessop's letter appeared to be demonstration of a prominent view of health promotion- that in a moral sense it was, essentially, OK. My experience at Warwick had shown

another sort of response to attempts at raising ethical difficulties with promoting health; namely that harassed practitioners should not be exposed to this kind of debate, because there is little they can do to change practice or priorities.

I knew of course that such views weren't uniformly held by those involved in health promotion; there were people who were interested in the moral dimension of this sort of work and who wanted to engage in debate and discussion about it. But health promotion was a relatively novel field of activity and academic endeavour. There were still essential uncertainties about its theoretical base and its rationale. In this context, it was worrying that there were some who felt there was no need for moral examination; or that such examination would somehow be unfair on practitioners.

This worry eventually overcame my diffidence in approaching an area quite clearly occupied to some extent by people with highly partisan views, about which they were very sensitive. I became more and more concerned to try and find my own answers to what I thought were two fundamental questions: what exactly are health promotion's moral problems?; and why is health promotion morally problematic? More than three years after I had started to think about these questions, my circumstances cleared sufficiently to allow me to register as a part - time MPhil/ PhD student. Within the constraints of a full - time job and home commitments, there was now some opportunity properly to engage with the questions.

## PLOTTING THE DIRECTION OF THE THESIS

The preface described the roots to the investigation this thesis represents. My intuitive feeling, based on experience of practice and the strong reaction aroused when the issue was mentioned, was that health promotion was an area in which moral investigation was important.

My first task, however, involved being clear about what health promotion actually is. I was engaged in activity that I thought was health promotion and could identify other things that might be seen as such. Was I, however, simply identifying activity and approaches that, because of my perceptions, had already been cast in my mind as problematic? Clearly, it would be easily possible to imagine some things that some people regarded as 'health promotion' and were obviously problematic- strongly coercive activities, for example. So I sought the 'voices' of a number of theorists to give me a provisional framework for understanding what health promotion is. These voices were also the first in a number of mediators through the thesis. I was exploring the understanding of others and not relying on my own construction of the world.

Even at this early stage, dispute about what health promotion actually is became evident at both theoretical and practical levels. Why was there such dispute? Arguably, part of the answer to this lay in separate interpretations of key concepts related to health promotion, and of its purpose. But these in turn might be better understood through considering the history of the development of the field and its underlying theory. I thus sought help for my problem through the examination of history.

One key struggle in this history was that of those involved in health promotion trying to convince others of the authenticity of their work- that it represented an important, arguably professional, activity. I therefore particularly explored the history of health

promotion's development as such an activity. Although I wasn't yet clear how and why, it seemed to me that the 'profession' of health promotion had important things to say about the morality- or otherwise- of the field.

By now, I had enough certainty of what health promotion was to imagine how it might be defended in a moral sense. Indeed, a number of the theorist voices I was listening to had constructed accounts of health promotion which- even if only implicitly- could be seen as elements of a supposedly robust 'moral case'. I therefore constructed such a case, using these voices. It was also sufficiently clear by now that the idea of attacking health promotion as an unambiguous good was unrealistic. There obviously were 'health promotion' activities problematic in an ethical sense. What it was important to explore was whether health promotion could be understood as a *prima facie* good.

My discussion (in Chapter Four of this thesis) identifies difficulties even with this claim for the nature of the good of health promotion. But at this stage, I was preoccupied again with the issue of whether it was simply my own perceptions and interpretations dominating. So I decided to explore the extent to which my views were shared by a number of health promotion practitioners. Was it as far as they could see a morally difficult field? If so, how did problems emerge?

Following this empirical work, which confirmed a shared view of problems, I returned to theory. In particular, I identified bioethics and the overlapping area of professional ethics as possible sources of help in understanding and dealing with the moral problems identified. It seemed important to explore assistance that might be available from bioethics because this is essentially the field exploring the assumptions, values and difficulties emerging from health care- of which health promotion has traditionally been seen as part (as my exploration of history confirmed). My interest in exploring possible help from the broad overlapping area of

professional ethics stemmed from my view- developed early on- that the possibility of 'professing' health promotion might form an important area of moral consideration in relation to the field.

Having gained some help from both bioethics and professional ethics, I took stock of my position, as well as those of my practitioner research participants. They had similarly been concerned not only to identify problems; but also to understand and possibly deal with them. We had all, then, charted our way around a reflective cycle: of practice, its review and a return to practice helped by a more robust understanding. Importantly, the processes by which we had done so- in particular our consideration of moral theory and our engaging in thought about practice and theory through the experience of writing- had supported this reflective cycle.

# CHAPTER ONE- WHAT IS HEALTH PROMOTION?

## 1. Introduction

The task of understanding and analysing the moral problems of health promotion must begin with an attempt to clarify what health promotion actually **is**. Can 'health promotion' be regarded as a definite article? If we are examining 'health promotion', are we in fact simply looking at particular activities that we might want to express a judgement about, or to which we might want to attach a value?

Certainly, there are some activities deemed to be 'health promotion'; and there are some people who do (either as all or as part of their job) work that they (and possibly others) see as 'health promotion'. Much of my thesis is concerned with deconstructing both these activities and these roles, as ways of becoming clearer about moral difficulties and what might be done about them. In this sense, the entire work is about asking the question, 'What is health promotion?'. My purpose in this chapter is to offer a broad account of how 'health promotion' has been conceptualised: how it might appear in practice; and who might be doing it. This will serve as a starting point for much more detailed exploration of these areas.

But even at this early stage, the profound confusion and dispute cloaking the promotion of health becomes apparent. Is 'health promotion' an 'it', or is it just 'things'? Does this matter for a project of moral enquiry? If 'health promotion' is conceptualised as a definite article, what values does this demonstrate: and what values are being displayed in competing conceptualisations?

## 2. 'Health Promotion Is....'

Some theorists have suggested that health promotion is something (a coherent entity): and that it can be defined in a relatively straightforward and circumscribed way (in other words, it is amenable to definition):

'Health promotion is any planned measure which promotes health or prevents disease, disability and premature death....' (WHITEHEAD AND TONES, 1991: 5);

'The term health promotion can be usefully employed.... as covering a realm of activity which is different in emphasis from the current power bases in health services, which indeed transcends health services and other formally provided services, and in which lay competence, the relevance of public opinion, the need for community involvement and the illusory nature of free rational choice are given due recognition....' (TANNAHILL, 1984: 196).

Thinking about 'health promotion is....' definitions raises problems in relation to the two interrelated issues of definability; and whether there is indeed a coherent entity to define. Consider the definitions above. In the case of the first, it is neat but tautologous: 'health promotion is any planned measure which promotes health' is a bit like saying my black bag is black. In the second, while the definition is longer and appears more substantive, this impression is only superficial. What is actually meant by health promotion 'transcending health services and other formally provided services'? What exactly should be understood by health promotion giving 'due recognition' to the 'illusory nature of free rational choice'? It all sounds rather metaphysical. The speed with which tautology and metaphysics have been encountered even through just limited probing of these definitions suggests that health promotion is both hard to define; and may not actually constitute a coherent entity.

Within both example definitions is the suggestion that health promotion entails action or activity of some kind. A different approach to the question, 'What is health promotion?', then, might be to try and classify or categorise the sorts of actions being done by people who try to promote health. (I am leaving aside for the moment the difficult question of actions that **unintentionally** might promote health.)

Since about the early 1980s, much energy has been devoted by some theorists (as well as some practitioners) to developing models (and taxonomies of models) which aim to describe and explain the territory of health promotion activity. I understand a model of health promotion to be something that tries to:

'Identify the common characteristics of a set of items or related processes which, when considered together, effectively provide a generalised representation of those items or processes....' (SIMNETT, 1991: 35).

Models can be either iconic (representing things as they are); or analogic (attempting to describe the world as if it resembled the model) (RAWSON AND GRIGG, 1988). Health promotion models are often presented within taxonomies, or systems of classification. Writers concerned with taxonomy development frequently attempt through their systems not only to describe, but also to compare and contrast the different models presented. As I will later argue, this is often in order that they can express (even if only implicitly) their support for the ideologies or values underpinning particular models.

I have drawn on the work of a number of well known writers to identify four clear models of (or approaches to) health promotion (EWLES AND SIMNETT, 1992: TONES, 1983, 1986a, 1986b, 1990; TONES, TILFORD AND ROBINSON, 1990; TONES AND TILFORD, 1994; BEATTIE, 1984, 1991; NAIDOO AND WILLS,

1994). Although there is some variation in terminology between these (and other) writers, they all broadly suggest the following health promotion models:

### i. The Medical/ Behaviour Change Model

People or populations are persuaded or strongly encouraged to alter or modify their behaviour if it is health- harming; and to take up preventive services for early detection or avoidance of disease. Service planning and implementation of activities are undertaken by the 'expert' health professional; and directed towards a lay 'audience' which passively receives, accepts and acts on what is offered or given. There is little or no question within such transaction.

An example of an activity which could be regarded as medical or behaviour change health promotion is childhood immunisation. Public health medicine professionals, on the basis of epidemiology and evidence of the efficiency and efficacy of vaccination in reducing certain infectious diseases of childhood (for example, measles, mumps and rubella) implement local immunisation programmes. Vaccination is widely available and parents are strongly encouraged to have their children protected in this way. Advice and information is often presented in a didactic way and parental choice is often assumed; parents will have their children immunised because it is undoubtedly the best course of action. Little if any time is spent in dwelling on any uncertainties that might surround the intervention or anxieties that parents or guardians may have.

### ii. The Educational Model

Knowledge and information is provided to individuals or groups to ensure understanding of issues and factors affecting health. This eventually facilitates informed choices and decisions about health and health- related behaviour. Although the person providing the information may still have 'expert' knowledge, the emphasis on facilitating choice means that they may see themselves- and hopefully will be seen- as a kind of 'gate keeper'. The model implies educational processes of teaching and learning, freely entered into. Arguably there is greater equality in the relationship between educator and learner.

An example of activity based on the educational model might be school sex education, subject to certain conditions of delivery. If the educator sees the learners as individuals with whom it is possible to engage for the development of their knowledge and skills: if they are seen as possessing the ability freely to choose a course of action (say, whether to have sex or not); and if learning and teaching is about promoting informed choice; then this might be activity promoting health according to the educational model. However, there are a range of variables in this kind of potential situation. This is not to mention the influence of others beyond the learning environment, some of whom might ultimately be controlling it. Such considerations may lead to the belief that educational model health promotion in the genuine sense of teaching and learning for informed choice might be difficult to achieve.

### iii. The Participant- Centred or Empowerment Model

Individuals, groups or communities are empowered to change and develop their society (if this is what they wish) so that possibilities for health are improved. Support

leads to co-operative participant- led work which identifies and meets health and health- related concerns. One of the aims of this model would be to ensure that it was 'lay' people rather than professionals who were determining and controlling the agenda.

The following might be an example of activity based on this model. A sprawling and run down housing estate suffers from a range of social and health problems including crime and levels of teenage pregnancy much higher than the national average. Workers encourage a group of residents to meet and discuss these and other issues. It emerges that the 'health need' of most concern is a safe play area for children. Workers support a residents' group in lobbying the local council for this kind of provision. The group is eventually successful in gaining resources. It plans, develops and manages the play area itself.

### iv. The Social Change Model

Focusing explicitly on the wider social and political determinants of health, this model advocates change to social, economic and environmental structures to improve health. It supports activity likely to achieve this kind of change. Activity might include policy and legislative development: fiscal control and regulation; and creation or alteration of environmental structures. Direct political action to achieve change would be permissible according to this model. The activities this model suggests would be undertaken by 'social changers' who would not necessarily consult much with the individuals or populations for whom they feel they are working to change structures.

Governments and other statutory bodies can of course be agents for social change through the kinds of mechanisms described above. It is also a role some voluntary

organisations are happy to adopt. An example of social change health promotion comes from the voluntary sector. A particular organisation is concerned to limit car use and promote public transport. It works with, and lobbies, a range of other organisations and bodies likely to be influential in this area including national and local government, employers, retailers and trades unions. Over a long period of time, it builds up support that is eventually sufficiently powerful to constitute political force. The government of the day acknowledges this and introduces planning legislation to limit car use and promote public transport provision; as well as fiscal incentives to abandon private transport.

## 3. Models as Expressions of Values: Some Initial Comments

Some theorists have tried to cast models as neutral and purely descriptive constructions. Others have argued it might be possible objectively to choose between models and the activities they suggest:

'In our view, there is no "right" aim for health promotion, and no one "right" approach or set of activities. We need to work out for ourselves which aim and activities we use, in accordance with our own professional code of conduct (if there is one), our own carefully considered values and our own assessment of our clients' needs....' (EWLES AND SIMNETT, 1992: 37).

Others argue a contrary position; that it is impossible to see models as anything other than expressions of ideology and preference for particular kinds of values. For example, different models imply different kinds of relationships between the person promoting health and her or his 'client', whether that is an individual, a group, a community or a population. Different relationships entail different sorts of power balance between those involved. If I believe that a health professional (for example, a

general practitioner) should control a particular health promotion activity, it is at least in part because I place value in the established role and position- the 'expert' status- of this professional. Alternatively, if I consider that it is individuals who should control their own lives, then I place value on their status and potential as skilled human beings rather than on any 'expert' professional. Models are also expressions of values in other ways. They try to claim certain things about the nature of health (that it is the absence of disease, that it is socially determined, that it is down to individual life choices and so on). In doing this, they attach value to particular activities likely to produce 'more health' according to the 'authentic' version of the concept they propose.

Ewles and Simnett's position- not unreasonably characterised as 'anything goes'- is therefore problematic for two reasons. First, it assumes the possibility of being able to choose completely rationally between approaches based on radically different sorts of values. Yet choices about which values are important to us are not determined completely rationally. Why someone has chosen consistently to support the values expressed by the Labour party as opposed to those of the Conservatives is complex. Certainly, though, the choice will be bound up in feelings, emotions and attitudes as well as in any reference to 'rational facts'. Equally, someone's preference for 'medical model' ways of working over 'empowerment' approaches is not solely the result of rational choice. Ewles and Simnett are not presenting an adequate account of how choices in doing health promotion are made.

Second, assuming 'anything goes' (even with the sort of caveats mentioned) removes normative purpose from health promotion. This could have alarming results, at least in part because of the potential for disputing the object of health promotion. A British National Party member could carefully consider his values and the 'needs' of his clients and come to the conclusion that the right health promotion action is the forcible repatriation of large numbers of the ethnic minority population from this country. If there is no 'right' health promotion aim or approach, then every approach is

equally right. Yet if considering health promotion models reveals anything, it is the belief that subscribers to particular models are strongly attached to certain kinds of values. A principal concern of this enquiry is to examine those values and consider their moral implications, which are frequently highly problematic. But suggesting choices about health promotion action can be mostly or wholly rational is even more deeply disturbing in an ethical sense.

## 4. Developing an Understanding of 'Health Promotion': The Emerging Problematic

I suggested earlier that in considering the question, 'What is health promotion?', it might be helpful to try to identify and classify activities which could be undertaken by those trying to promote health. Yet models and taxonomies describe such a broad range of possible activity that it is natural to ask, 'Can **all this** be seen as "health promotion"?' An obvious response- yes, if it promotes health- simply leads back to the tautologies with which I began (and possibly to difficulties of the 'anything goes' variety as well).

There are at least two options at this point in understanding what health promotion is. First, it can be accepted that it might comprise all the things implied or made explicit by the models or approaches described above, and attempting close justification of this acceptance. Second, it could be argued there are some things within this very broad range that can more properly be understood as 'health promotion'. Both these options pose problems.

If I accept that the very broad range of things is 'health promotion', I leave myself open to at least two accusations. The first is of failing to be clear about why I am not concerned to examine activities which 'promote health' **unintentionally** (CRIBB,

1993). The second is of accepting that arguably very un- health promoting things (for example, highly coercive action literally forcing people to give up smoking) are in fact 'health promotion'. These accusations are deeply problematic for the moral enquiry I propose. I am bound to be led to the obvious conclusion that some kinds of 'health promotion' raise more ethical dilemmas than others and that because of this all activity should be treated, at least initially, with scepticism. Further, if 'unintentional' health promotion is allowed (and there is no clear reason why it should not be, if the 'all things' approach is taken), I am faced with the unenviable prospect of having to be sceptical, in a moral sense, about any activity which could conceivably have some sort of impact on health. But how useful would such a conclusion be? It seems to provide little sense of the landscape's light and shade, of complexity and difficulty, things which above all I am concerned to try and reveal. It is rather like undertaking a moral investigation of 'war' in a general sense. The researcher reaches the conclusion that because of what 'war' is (pain, suffering and so on), we must always be ethically inclined against it. But sometimes a war (fought against an oppressor or a tyrannical regime, for example) can be seen as moral; or rather, the purpose of a particular war can be seen as such. The most fruitful ethical examination of 'war' is likely to be that which moves beyond examination of its general features (bound to be repugnant in a moral sense) towards a deeper understanding of particular cases.

This might also be the case with 'health promotion'. As a first step to such deeper awareness, we might be inclined to accept the second option in understanding what health promotion is; there are some things which should more properly be regarded as 'health promotion'. Yet this also holds problems. If I accept some of the range of activities as more properly constituting 'health promotion', on what basis have I made this selection? If it has been made at random, it will be impossible to justify in any rational sense and I will be subject to accusations of relying solely on personal preference or value. Such accusations will apply whether I eventually end up regarding the activities sympathetically or not. If they are viewed in a gentle light,

there will be an inclination to think, 'I told you so- he chose these things as "health promotion" because he *a priori* believes them to be acceptable.' If they are seen harshly it will be, 'They are "health promotion" because he refuses to see the worth of this kind of activity'. Alternatively, if I apply certain criteria to my selection of what constitutes 'health promotion', what will they be? The extent to which the activity actually improves health? But how will this be measured and what is meant by that anyway? The extent to which autonomy is promoted or protected? But again, how will this be measured and in any case isn't this once more making moral judgements before the fact? Objective criteria for deciding on the legitimacy of activity in this area are extremely hard to come by and any produced will be liable, as before, to accusation of bias.

To summarise the problematic emerging from these initial difficulties in definition and description for a moral enquiry into health promotion. If 'anything and everything' is health promotion, it is likely ethical difficulties identified will be very general (and thus their revelation not especially helpful for practice). If attempts are made to 'pin health promotion down', then that selectivity could well be seen as shaping the nature of the enquiry.

For the moment, I want to set out in broad terms my strategy for managing the problematic. What I plan to do is to use **others'** understanding of 'health promotion', as far as possible, as the basis for my moral examination of the field of activity. Later on, I will be building a putative ethical argument for health promotion. This will be derived from theorists influential in the field. I will also be considering, again through my understanding and interpretation of important theorists, ways in which the field's 'moral problems' have so far been understood and interpreted. Yet another part of my thesis will involve analysis of health promotion practitioners' perceptions of the ethical difficulties they face. It can therefore be seen that a variety of voices will be articulating the nature of 'health promotion' and mediating between it and myself as a

researcher with particular questions to ask and with my own particular values. It may still be argued, of course, that my particular choice of supposedly mediating 'voices' in fact suits my own agenda. I acknowledge the possibility of 'researcher bias' and will continue to reflect on this as my thesis develops.

## 5. Who Does Health Promotion?

During this moral enquiry into health promotion, I will at various times be discussing activities undertaken by occupational or professional groups that could be called 'health promotion'; as well as exploring the conceptual and theoretical underpinnings to such activities. A good case could be made for seeing 'health promotion' as an international endeavour and a force for global change (WORLD HEALTH ORGANISATION, 1984: 1986). However, my work will centre almost exclusively on the United Kingdom (UK) experience. I concur with those who view the promotion of health as a global effort. A given society, its politics and its culture, though, are important explainers of the moral dilemmas health promotion contains and represents. I am interested primarily in the way in which the construction and operation of UK society has shaped the ethical problems facing the field with which I am concerned.

It is important to draw a central distinction between the different kinds of people who have a professional or occupational role in health promotion within the UK. The distinction is between the **health promotion specialist** (HPS); and the **health promoter**. The Society of Health Education and Health Promotion Specialists (SHEPS) draws the distinction thus:

'Within the field of health promotion, there are two groups of workers.

'The first group are called **health promoters**. For this group, health promotion is part of a wider professional role. They come from a range of agencies and include teachers, health visitors, environmental health officers, practice nurses etc., and are usually involved in promoting health to the public directly....

'**Health Promotion Specialists** promote health in several ways including:

'* By supporting health promoters (see above) in their health promotion role. This may involve training, advising or helping develop and evaluate specific health promotion projects, or providing audio- visual aids;

'* By working with decision- makers and managers to assess need, develop policies and strategies to make healthier choices easier choices;

'* By developing campaigns and working with the media to raise awareness about health issues with the public directly;

'* By working and consulting with communities and voluntary groups to enable them to have more control over their health;

'* By co-ordinating multi- agency work....' (SOCIETY OF HEALTH EDUCATION AND HEALTH PROMOTION SPECIALISTS, 1997a).

It is likely the exact nature of the HPS 'job description' supplied by SHEPS could be disagreed upon. It reflects the way in which this occupational association idealises the work its members do. My own experience as a HPS was of spending much more time on some of the activities described and much less (or none at all) on some of the

others. However, the distinction between HPSs (in some areas titles vary between this and others such as health promotion officers, advisers or co-ordinators) and health promoters can be accepted. Health promoters work directly with members of the public (patients, pupils, parents and so on) and have the promotion of health as part of their professional role. HPSs generally work with and through professionals (health promoters), have a co-ordinating and facilitating role and spend most or all of their occupational lives working on health promotion. It will become clear as my thesis develops that this distinction between roles in health promotion has an important part to play in understanding and interpreting its moral difficulties.

## 6. A Brief Note About History

Health promotion is an aspect of public policy. The kinds of things both health promoters and HPSs do are driven by political decisions. Nor is the conceptual and theoretical development of health promotion immune from policy making and policy changing. For example, the recent resurgence of interest at policy level in the relationship between social inequalities (of income, access to education and so on) and health status has led to different ways of interpreting and relating theory to practice. (See, for example, SOCIETY OF HEALTH EDUCATION AND HEALTH PROMOTION SPECIALISTS, 1998a.)

Rapidly altering political and social contexts cause difficulties for those who are writing about health promotion. I began the research leading to this thesis in 1993, shortly after the publication of a (then Conservative) government white paper on health improvement (SECRETARY OF STATE FOR HEALTH, 1992) vigorously criticised by some for its 'lifestylism'. As I write this chapter, a little less than six years later, the political landscape has altered and new policy priorities are being shaped.

As I understand them, difficulties connected with rapid change relate less to the applicability of argument and more to the practicalities of deciding on historical scope. I am confident that the application of moral philosophical enquiry to this field will be of relatively enduring help. It should become clear that while detail may change, fundamental problems (for example, determining the extent of individual and state responsibility for health) remain remarkably consistent. But accounts and analyses of health promotion have to stop somewhere in time, much like accounts of any other sphere of theory and activity. One of the focuses of this thesis is on a number of health promotion practitioners who describe and discuss the ethical problems they face in their work. These views were collected from 1995 to 1997. It would seem sensible to suggest provisionally that this latter date provides the 'cut off' for historical scope. However, it would also be wise not to suggest that history ended in 1997; and to provide at least pointers to events and happenings between then and now (that is, the time at which this thesis took the shape it finally has). I will therefore try to provide these, while suggesting there are good reasons for concentrating mainly on rather earlier times.

## 7. Conclusion

In this chapter, I have briefly outlined the nature of health promotion, using so- called models and the activities they imply as a way of doing so. Given the deeply contested and value- laden nature of the field, I have outlined a key problematic facing anyone trying to examine it.; to what extent are personal interpretations and values influencing the way examination is undertaken? This issue will remain of central importance within this research and reflection on the moral problems of health promotion.

# CHAPTER TWO- THE DEVELOPMENT OF HEALTH PROMOTION: A SHORT HISTORY

## 1. Introduction

In Chapter One I sketched out a preliminary description of health promotion. But even at this early stage it is clear there are major difficulties in understanding what health promotion is and what it involves. These problems of definition and description are likely to have a significant impact on moral enquiry into this field.

Building further an understanding of health promotion and its complexities is likely to be supported by considering its history. How has health promotion developed? In what ways has it influenced- and been influenced by- the political, social and cultural environment of which it is part? I will address these questions as further preparation for my examination of moral problems.

There are some difficulties in constructing a history of health promotion. Secondary sources in the form of direct historical accounts are rare, although a number do exist. (See, for example, SUTHERLAND, 1979: BLYTHE, 1986; EWLES, 1993; NAIDOO AND WILLS, 1994; KATZ AND PEBERDY, 1997. I have used all of these to support my own account.) Such sources tend to be brief and descriptive. They are not interpretative in any substantial sense. There is a much larger number of secondary sources indirectly relating to health promotion which I have used. I have also had access to a collection of primary sources which particularly relate to developments in the occupational association for health promotion specialists over roughly the last decade and a half.

From these sources it is possible to construct a chronology of events important in the development of health promotion. It is also possible to identify five recognisable and

closely interconnected dimensions to a history of the field of activity and its conceptual and theoretical underpinnings:

* The dimension of the wider social and political context within which health promotion takes place (YOUNG AND WHITEHEAD, 1993);

* The dimension of the history of epidemiology and the control and treatment of disease (given the field of health promotion is frequently, for better or worse, associated with disease prevention) (TONES, 1993);

* The dimension of the history of debate about what health promotion is and what it involves ;

* The dimension of the history of health promotion's development and practice in various settings (for example, primary health care and schools);

* The dimension of the history of health promotion's development as an occupational activity (or as an activity undertaken as part of an occupation).

In this chapter, I explore mainly the first four of these dimensions of a history of health promotion. In Chapter Three, I focus specifically on the fifth historical dimension; the development of health promotion as an occupational (possibly a professional) activity.

## 2. Key Chronological Landmarks in the Development of Health Promotion

One prominently held view is that health **education** is a long- established field of activity; whereas health **promotion** is a relatively novel phenomenon (DOWNIE,

TANNAHILL AND TANNAHILL, 1996: 27). This view depends on regarding both health education and health promotion, together with their histories, in a certain way.

Health education, according to this view, is a kind of 'sub- category' of health promotion, mainly concerned with the use of educational methods to convey health messages. It has been argued that the recent history of this sort of activity can be traced back through the twentieth century, with some roots in the nineteenth (BLYTHE, 1986). On the other hand, health promotion addresses imperatives for heath improvement in a much broader way. It embraces the 'sub- category' of education for health, but also concerns itself with trying to influence social, economic and environmental policy in favour of health. This broader concept and field of health promotion is generally thought to have emerged in the early 1970s (KATZ AND PEBERDY, 1997: 58).

However, the notion of a 'health education-then-health promotion' account of history is problematic. It fails to include, or offer explanation of, an important phase during which the health of the population of the United Kingdom dramatically improved. This was the period of the great Victorian public health reforms (ASHTON AND SEYMOUR, 1993).

If a comprehensive history of initiatives for health improvement in the UK (distinct at the moment, for the sake of argument, from health promotion) was being assembled, I argue it would have to try and account for at least the following phases:

* Nineteenth century public health reform (from about 1840 onwards);

* The growth of health education (from about the end of the nineteenth century);

* The emergence of health promotion (from the early 1970s).

The literature shows little evidence of attempts to provide coherence in historical accounts of UK health improvement activity. Blythe's (1986) account- admittedly focusing on health education- is nevertheless almost paradigmatic in its separation of the three phases I have argued require attention. He begins almost at once by distinguishing health education, as he sees it, from public health:

'Modern health education practice in Britain has virtually grown up with the twentieth century, with a number of penetrating nineteenth century roots. The first roots formed at the time of "the cholera" which visited the country in three fearsome epidemics between 1831 and 1868, to which period the distribution of the earliest health leaflets can be traced....' (BLYTHE, 1986: 105).

Blythe suggests that health educational practice (here leaflet distribution) is distinct from the activity of what in his next paragraph he terms 'the public health movement'. At the end of the paper, several pages on, he wonders:

'Perhaps the greatest barriers in this field are, however, still the same as a century ago: the low appeal of prevention and the considerable ignorance surrounding health promotion....?' (BLYTHE, 1986: 115).

It could be asserted that a further barrier is the lack of conceptual clarity and historical interpretation which has led Blythe to 'sandwich' health education between public health and health promotion. I will later argue for an interpretation of history which allows greater coherence and a stronger notion of 'tradition' to emerge for the field of health improvement as a whole. This interpretation also has some power in explaining the rich seam of dispute running through the history of health improvement understood as 'health promotion'. For the time being, though, I will in turn briefly review each of the phases I have identified above.

Victorian public health reforms and action were responses to the new and fundamental dangers to health posed by the industrial revolution; and by the rapid urbanisation of large parts of Britain from the beginning of the nineteenth century onwards (YOUNG AND WHITEHEAD, 1993). Much of this new urban population existed in conditions of gross poverty, continually subject to disease on epidemic scale. Legislative action- in particular the 1848 Public Health Act- followed connections made, for example by Chadwick (1842) between poverty and ill health. But this action was not primarily for reasons of social justice. Rather, improvements in such things as sanitary conditions and water supply were dictated by a desire to maintain and improve national economic efficiency through keeping populations strong enough to work. There was also a substantial imperative for social and moral stability.

Whatever reasoning lay behind it, by the end of the 19th and beginning of the 20th centuries public health reform had resulted in a general decline in environmental hazards. In addition, the very beginnings of what might now be termed 'the welfare state' were emerging. The Liberal government of Lloyd George introduced national health insurance provision in 1911 (although once more this was largely for economic, as opposed to intrinsically health, reasons).

These public health developments coincided with rapid progress in the field of what could be called 'personal medicine'. This progress extended well into the twentieth century. First came development of the germ theory of disease, from which followed immunisation and vaccination. Then the 1930s and 1940s saw the advent of the therapeutic era, including the discovery and eventual mass production of penicillin (RIEDMAN AND GUSTAFSON, 1995). Medicine assumed a profound confidence in its ability to counter cases of individual illness and disease (YOUNG AND WHITEHEAD, 1993: ASHTON AND SEYMOUR, 1993). This focus on personal

medicine and its 'magic bullets' meant reconception of public health and its purpose. It shifted from its environmental roots largely to playing a supporting role to the enterprise of personal medicine (FRENCH, UNPUBLISHED).

The high tide of medicine, perfectly matched to the modern age, meant that it alone claimed credit for the undoubted dramatic improvements in health (by almost any indicator) enjoyed by the UK population in the first half of the 20th century. The corollary to this was a remarkable decline in the belief that health could be improved by focusing on environmental and social measures. The view that health improvement depended on personal medicine and its continuing advance was widespread (a view, as will be seen, later to be challenged).

Given this state of affairs, it was natural that the 'medical model' should dominate health education during this period (TONES, 1993). Individuals were to an ever greater extent seen as holding personal responsibility for their health: for co-operating in its maintenance through the expertise of preventive medicine; and for submitting to medical treatment when things went wrong (SUTHERLAND, 1979). Health education simply played its small and relatively insignificant part in medicine's grand project.

If there were any 'high water marks' for health education in the first half of the 20th century, they were probably around the periods of the First and Second World Wars. For war brought threats to health unconventional in the sense that personal medicine was not wholly or partly able to provide the solution. During the First World War, it was reported that up to 20% of Britain's military personnel were suffering from venereal disease (VD). This alarming news resulted in the first ever Government support grant (equivalent to almost £1 million in today's terms) being given to the National Council for Combating Venereal Disease in support of its health education efforts against VD (BLYTHE, 1986). Equally, World War Two military planners

were concerned that mass bombing of cities (never before a feature of warfare) would result in disease of epidemic proportions. The Central Council for Health Education (CCHE), previously a peripheral organisation, took on a more central importance and worked with the Ministries of Health and Information on plans for campaigns- for example to promote immunisation against diphtheria (this in fact resulted in a rise in such immunisations of children from 8 to 62% during the period 1940-45) (BLYTHE, 1986).

In 1945, following the end of the Second World War, a Labour government was elected to power. It set about creating a coherent welfare state, aiming to banish Beveridge's 'five giants' of Want, Disease, Ignorance, Squalor and Idleness (HIS MAJESTY'S STATIONERY OFFICE, 1942). The National Health Service (NHS) was created in 1948; community health services (the public service grouping most naturally inclined towards health education) took their place in local authorities. From this base, professionals such as health visitors were involved in health education according to the 'medical model'- didactic advice and information giving and so on. They were themselves under the control of aptly titled medical officers of health. Nominally the Ministry of Health had strategic responsibility for health education: there was little supporting national or local policy work; and there was hardly any attempt to move towards a critical understanding or awareness of the scope and limits of health education (EWLES, 1993). With the receding of unconventional threats to health, the field of health education returned to the backwaters. These were hardly disturbed by the arrival, for the first time, of a tiny occupational group (less than twenty for most of the 1950s)- health education officers.

There were only two important interruptions to a period of roughly twenty years (from the early 1950s to the early 1970s) during which largely unevaluated, medical model health education was the order of the day. The first was the publication of the Cohen Report (MINISTRY OF HEALTH, 1964), the product of the committee of

national enquiry into health education chaired by Lord Cohen. This had been prompted by a number of developments, including a growing concern of local authorities for more robust health education services. It recommended limited- and to some extent independent- development of health education structures. These included the establishment of a central health education board for England and Wales, stronger than the emaciated CCHE. This board was eventually formed as the Health Education Council (HEC) in 1968, although in its relationships it had much the same odd hybrid character as the CCHE. It was neither independent from, nor part of, central government. Cohen also recommended the development of specialist health education structures at local level.

The second interruption was the publication of 'Prevention and Health: Everybody's Business' (DEPARTMENT OF HEALTH AND SOCIAL SECURITY, 1976). This was the closest a UK government had yet come to a policy statement on health improvement. While it was still heavily in thrall to the medical model- its emphasis firmly on individual lifestyle change as the route to better health for the nation- it did at least provide some sort of strategic focus for health education. 'Prevention and Health' was in part inspired by mounting political concern at the escalating costs of treatment and care in health services (HAM, 1985). Concern increased as the fortunes of the UK economy declined in the early to mid- 1970s.

The publication of 'Prevention and Health' was followed, three years later, by 'Rethinking Community Medicine' (UNIT FOR THE STUDY OF HEALTH POLICY, 1979). This report suggested much more radical action to address the negative social and economic determinants of heath. Perhaps more accurately than 'Prevention and Health', it reflected a growing view (in some circles) that medicine by itself could actually have very little impact on the overall health of western populations.

There were two roots to such a view. The first was the increasingly accurate mapping being undertaken of the relationship between social and economic circumstance and health. This was exemplified by The Black Report (TOWNSEND, DAVIDSON AND WHITEHEAD, 1988). Black presented compelling evidence- rejected at the time of his report's 1980 publication by what was now a Conservative government- that health depended on much more than access to basic medical services or the ability to change aspects of lifestyle.

The second root involved fundamental attacks on the primacy of medicine itself. In a seminal and model study, McKeown (1976) presented evidence for the case that decline in tuberculosis (TB) mortality- a major killer for much of the preceding hundred years- should in fact be mainly explained by the vast improvements that had taken place in social and environmental conditions over this period. Medical advance had really been of secondary importance in countering TB.

McKeown's compelling empirical evidence was amplified by even more radical challenges to medicine which were mounted at around the same time. Critics, most notably Illich (1977), argued it was not only the case that the effects of medicine on health had been overblown; but also that its activities had been positively health-harming- iatrogenic.

This radical questioning- together with the growing belief that health and illness were complex social phenomena not understandable purely through pathology and aetiology- combined to produce an effective challenge to traditional medical practice. By implication this challenge embraced both 'medical model' health education and dominant conceptions of public health. (As recently as the end of the decade before that in which Illich was famously writing, it was being argued that the primary function of public health was to support **individual adjustment** to an unhealthy environment (MORRIS, 1969).) Although it would be impossible to argue that

traditional conceptions of medicine and health were completely overturned by Illich. McKeown and other writers, there is little doubt that their work- together with the cumulative effect of the political-economic climate of the time- led to the beginning of what Ashton and Seymour (1993) regard as a new phase of public health.

There are a number of early landmarks representing the so-called 'New Public Health'. These include 'A New Perspective on the Health of Canadians' (LALONDE, 1974). Marc Lalonde, then Canadian Minister of Health, argued that social and environmental improvements, perhaps more so than medical services, were likely to yield better health for the citizens of Canada. 'A New Perspective on the Health of Canadians' is often seen as having provided the stimulus for World Health Organisation (WHO) declarations during 1977 and 1978. The 1977 declaration, 'Health for All by the Year 2000' (WORLD HEALTH ORGANISATION, 1977) committed member governments of WHO to ensuring that their main social targets should relate to attainment by all their citizens of levels of health by the year 2000 such that they would be able to lead economically productive and socially fruitful lives. Importantly, the eventual European targets for 'Health for All' (WORLD HEALTH ORGANISATION, 1985) embraced social and environmental ones as well as those concerned mostly with disease reduction. The 1978 (Alma Ata) declaration underpinned 'Health for All' by putting primary health care at centre stage as the vehicle through which it would be delivered.

Seven years were to elapse from the publication of the first set of European targets until the then UK government produced its own targets for health improvement for England, Scotland, Wales and Northern Ireland (HEALTH PROMOTION WALES, 1992; NORTHERN IRELAND OFFICE, 1992; SCOTTISH OFFICE, 1992; SECRETARY OF STATE FOR HEALTH, 1992). I will focus more closely on these, their political and social context and their relationship to the supposedly newly emerging concept and field of health promotion in the following sections.

At this point, however, it is worth adding an interesting and important coda to the mapping of the rise of health promotion in the context of society and medicine. It can be argued that health promotion emerged at least partly because of a mistrust in medical power alone to deal with illness and disease; and because of a growing belief in the importance of social influences on health. Ironically, though, it was disease that can be seen as largely responsible for the relatively exponential increase in public expenditure on the field of activity from the mid- 1980s onwards. The disease was, of course, HIV/ AIDS. The arrival of the AIDS pandemic in the early part of that decade, together with the failure of medicine immediately to 'deal' with it in terms of 'discovering a cure' alarmed politicians in both the United States (SHILTS, 1988), the United Kingdom (BERRIDGE, 1996a, 1996b) and other developed countries. Berridge, writing about the UK situation, argues that the seeming powerlessness of medicine prompted government action on the prevention/ health promotion front (BERRIDGE, 1996b: 21). This action may largely be characterised as 'medical model' health education (partly because of the nature of the times, and partly because of the nature of the disease). Again, while other non- governmental organisations and groups certainly approached HIV/ AIDS in more radical ways (for example, through methods of community participation); at their core they were always focused on disease prevention. The greatest irony of all is that in the midst of the era of the 'New Public Health', health promotion's biggest triumph was to attract the attention of politicians and public because it provided hope in protecting individuals against disease.

## 3. Disputed Territory (1): Approaches to Health Promotion in the 1980s and 1990s

My account of the historical development of health promotion in its social and epidemiological context has been broken at a particular point- towards the end of the 1970s and the beginning of the 1980s. Some theorists suggest a sudden flowering of a new genus- health promotion- around this time. For example, Yeo (1993) talks of the emergence during this period of a 'reform movement' trying to influence economic, social and environmental policy in order to achieve 'Health for All'. Macdonald and Bunton (1992) assert that health promotion 'as a term and concept' first appeared at the time of Lalonde (1974).

Persisting with what I will later argue is the mistaken 'health education- then- health promotion' interpretation of the history of the field, it is natural to suggest that the late 1970s and early 1980s were a watershed in this history. Health promotion now having been 'born', it is possible to move to historically accounting for this supposed 'new' entity. Yet even if there were such a thing as a clear cut 'birth' of health promotion, there is great uncertainty about what actually emerged, as much of the 1980s and onwards were filled with debate and dispute about its nature, what it involves and what it excludes.

Debate was partly to do with demarcation; there were many attempts to define and describe the legitimate scope, limits and activity of health promotion. (For example, see TANNAHILL, 1985: DOWNIE, TANNAHILL AND TANNAHILL, 1996; FRENCH, 1990.) But debate about demarcation often also contained dispute about ideology, either implicitly or explicitly. Some academics and practitioners expressed regret and surprise at the way in which 'health promotion'- doubtless being seen as bestowed from on high by Lalonde, the WHO and the likes- had been enthusiastically taken up by specialist UK health education practitioners (FRENCH, 1985). In an

important article, Williams (1986) argued there was no coherent version of 'health promotion', save one that was likely to entail heavy handed 'selling' and marketing. This writer claimed that such activity was in lamentable contrast to the honest job of individual development undertaken by those involved in health education.

There was not only doubt and disagreement about the apparent wholesale 'replacement' of health education by health promotion. There was also dispute about the question of what health promotion should be trying to do. Some of this related to different political perspectives. For example, libertarians such as Anderson (1990) argued that health promotion should simply be encouraging individuals to take responsibility for their own health behaviour. On the other hand, people of communitarian or collectivist persuasion (bolstered by things such as the reasoned enquiry evident in the Black Report) advocated broad societal changes based on their view that ill health and disease were largely caused by structures.

The relative intensity of this dispute in the UK is in part explained by the nature of the political times in which it took place. The 1980s were politically and socially very different from any other post war decade. 'Economic realism' on the part of the Conservative government elected in 1979 led to at least the perception of new and dramatic curbs in public expenditure. (Although 'cuts' are now associated in the public eye with the advent of the Conservatives in that year, the previous Labour administration had placed tight reigns on public spending (COLE, 1995: 178).)

Spending curbs represented a fundamental breach in what up to that point had been a political consensus on the role and nature of public services. Before 1979, both major political parties had by and large agreed that the welfare state and services associated with it were essential factors in maintaining social and economic stability. Mrs Thatcher, Prime Minister from that year onwards, sought to implement policy based on the requirement of the individual to make provision for her or his survival and

thriving. Accompanying this was the belief that those who wanted had a perfect right to choose whether to use public services, or to opt for another form of provision. (Some commentators- for example, Hutton (1995)- have argued that the needs of those unable to exercise those kinds of choices were irrelevant to the policy makers.) Measures were taken deliberately and continually to ensure pluralism, deregulation and privatisation in almost every aspect of what had previously been seen as the preserve of public service (LEATHARD, 1990).

Such political libertarianism strengthened and gave credence to libertarian ideologies within health promotion. In the same way that the creed of libertarianism in the wider political arena was arguably never effectively challenged for much of the 1980s; so those pressing for more radical structural approaches to health promotion were never able to shift the essentially libertarian nature of policy in this area. (For examples of such policy, see Secretaries of State (1987); and Secretary of State for Health (1992).) For the structuralist, it must have seemed as if the devil was the only one able to play any tunes at all. Indeed, it has been suggested (MCKEOWN, 1995) that theoretical arguments on the nature and focus of health promotion in effect played into the hands of Conservative politicians; more effort was spent on this debate than on challenges to structures causing ill- health.

The ideologies and actions of the dominant UK political force in the 1980s did not only have the effect of characterising the nature of 'official' health promotion. Public expenditure curbs and public sector 'deregulation' also directly affected how, where and with what limitations health promotion practitioners worked. To demonstrate this it is necessary to consider the development of health promotion during this period in key 'settings'- the fourth dimension of my history of health promotion.

## 4. Disputed Territory (2): Settings for Health Promotion in the 1980s and 1990s

Settings can be understood as catchment areas for approaching a specific population group such as primary health care patients or school students. More technically, they can also be regarded as a framework for planning health promotion activity ; their features and structures can actively support the promotion (or demotion) of health (BARIC, 1996). My use of the term here is mainly in the former sense. In an influential review of the effectiveness of health promotion, Tones and Tilford (1994) identify five settings. However, this historical account will concentrate on just three. They are those where it is reasonable to believe the consolidation or development of health promotion has been most marked; or alternatively most disputed or problematic. My concentration is on the settings of health care (mainly primary health care): communities as represented by local authorities (although I acknowledge the limitations of such representation); and schools.

Health promotion probably developed most strongly during the 1980s and early 1990s in the primary health care setting. In the early 1980s, a number of reports by the Royal College of General Practitioners (RCGP) were influential in establishing the view that primary care allowed the opportunity to influence individuals to change their health behaviour, particularly those aspects of it thought to be linked to cardiovascular disease (ROYAL COLLEGE OF GENERAL PRACTITIONERS, 1981, 1983, 1986). Given the Conservatives' desire both to promote individual responsibility and to reduce health care costs, it was quite natural that the development of so- called 'anticipatory care' should be encouraged. Such encouragement was confirmed by the publication of the White Paper, 'Promoting Better Health' (SECRETARIES OF STATE, 1987). This was billed as the government's programme for improving primary health care and had a strong focus on health promotion, where this is understood as specific preventive activities and lifestyle advice. In particular, the White Paper proposed a system of incentive

payments to general practitioners (GPs) to run so-called 'health promotion clinics'. In practice, these 'clinics' usually involved a practice nurse (rather than a GP) giving advice on a range of topics (for example, smoking cessation or the prevention of obesity) to individual patients or sometimes to small groups. Implementation of the system was not without problems. In particular, it was vulnerable to the criticism that it was impossible to be quite certain about the quality of the interventions being undertaken; while some general practices would certainly be taking their responsibilities seriously, others might be 'cashing in' on the system (EWLES, 1993).

General practitioners who were keen on health promotion could well have been distracted by the major change that swept the NHS in 1990. The NHS and Community Care Act of that year (preceded by the White Paper, Working for Patients (DEPARTMENT OF HEALTH, 1989)) enforced a 'split' in health service organisation and the creation of a so- called 'internal market' for health care. On the one hand, there were to be bodies responsible for 'buying' health care for their populations ('purchasers'); and on the other there were to be bodies responsible for providing this health care ('providers'). I will discuss the 1990 changes in more detail in the following chapter when I consider their impact on practitioners of health promotion (particularly health promotion specialists). For the time being, it should be said that GPs were to be pivotal in this new system. Despite the frequent conspicuous absence of appropriate training or experience: and despite the 'independent contractor' mentality pervading this occupational group; family doctors were encouraged to take on a 'purchasing'- type role. In its most acute form, this involved general practices becoming 'fund holding' and taking direct responsibility for purchasing health care for the patients on their lists. Successive waves of practices became fund holding almost from the beginning of the reforms and as they did it became harder for the remainder to resist pressure to go the same way. Fund holding GPs used their financial power to extract the best possible services for their own patients, frequently at the expense of those on the lists of neighbouring, but non- fund holding, practices (HUTTON, 1995).

The reality was that both fund holding and non- fund holding general practitioners were increasingly occupied by the rigours of the quasi market place for health care (FRANCOME AND MARKS, 1996).

England's health improvement White Paper, 'The Health of the Nation', was published in 1992 (SECRETARY OF STATE FOR HEALTH, 1992), along with equivalent documents for other UK countries (HEALTH PROMOTION WALES, 1992: NORTHERN IRELAND OFFICE, 1992; SCOTTISH OFFICE, 1992). Although specific targets and target areas varied between the documents, there were broad proposals for action in all of them around the key areas of cardiovascular disease: cancers; mental health; accidents; and HIV/ AIDS. Primary health care was emphasised once more as a key vehicle for health improvement. The White Papers were accompanied by guidance on what was required to support meeting of disease reduction targets set- for example, through the 'novel' method of alliance working (DEPARTMENT OF HEALTH, 1993b). The health improvement White Papers gave the government an opportunity to change the increasingly ridiculed 'health promotion clinics' system. Practices were supposedly to be rewarded in a progressive manner, according to the level of work they undertook and the extent to which this embraced the needs of the population they served (as opposed to individual patients). The replacement system appeared to allow more flexibility in how health promotion was interpreted and undertaken, but it was still centred on individual lifestyle change (not least because the White Papers themselves were so firmly in this mould). The system was changed yet again before the eventual defeat of the Conservatives in the 1997 General Election.

A little before this date, evidence was published suggesting that despite policy concentration on primary health care, its ability genuinely to promote the public health was extremely limited. General practitioners were tied to conceptions of health based on individual responsibility; and unable even to do much in this respect because

of accounting, financial and other organisational demands placed on them by the internal market (RUSSELL, 1995). It seemed that more than a decade after the RCGP had identified the bright promise of prevention held within primary health care, the importance of its role in health promotion (particularly when this was interpreted as extending beyond individual responsibility) was often questionable.

Moving from primary health care setting to local authorities, it is possible to see health promotion also developing in this setting during and beyond the 1980s (although again not without difficulty). In 1974, local authorities- up to this year having responsibility for community health services- lost this role to the NHS. There was a certain irony in the fact that as the case against medicalisation became more and more clear, community health care professionals (who were possibly those most likely to work with alternatives to the medical model) were subsumed into the state monolith arguably preoccupied with its perpetuation. However, the research evidence gathering in the late 1970s and early 1980s on the strong connection between poverty and ill-health prompted some local government re- assessment of its role in health improvement. Once more, the Black Report and related work- despite rejection on ideological grounds by central government- assumed influence. It pointed, for example, to the profound impact on health of traditional local authority responsibilities such as housing.

The emergence of health promotion on the local authority agenda during the 1980s was also inspired by the 'Health for All' movement, which also had as its focus structural causes of ill- health rather than individual 'risky lifestyles'. The collectivist-type agenda of 'Health for All' appeared attractive to some local politicians. This was especially so for those in metropolitan areas where evidence of health inequalities was frequently most compelling; and where elected representatives together with their officers were often of different ideological persuasion to the Conservative central government. Inevitably, national policy- making demonstrated hostility towards local

efforts to influence health at structural level (MORAN, 1986). In any case, the Conservatives, while ambivalent about it at the beginning of their period in government (YOUNG, 1990), were gripped by the middle 1980s with what turned out to be their own grand project of privatisation, with the attendant notions of deregulation and pluralism in service provision. Clearly this was in marked contrast to the aspirations and practice of 'Health for All' . (There was, however, a paradox here. Conservative hostility to local authorities with 'Health for All' agendas belied the fact that Mrs Thatcher's government was itself a signatory to the 38 European targets.)

The final health promotion setting whose development will be briefly reviewed is that of the school. State education provision was traditionally a local authority (county or metropolitan borough) responsibility. This setting was also, therefore, heavily influenced by the political orthodoxy of libertarianism; and the desire to deal with all opposition to the orthodoxy through centralisation. Increasingly interventionist government policy resulted in legislation- particularly the Education Reform Act 1988 (DEPARTMENT OF EDUCATION AND SCIENCE, 1988)- which as a by-product had profound implications for schools health promotion.

Central government education reformers moved in two kinds of ways to strengthen their control of the state school system. The first way can be thought of as organisational or managerial. In particular, schools were encouraged to 'opt out' of local authority control, the incentive for doing so being that it was possible to receive favourable grants directly from central government (HUTTON, 1995: 215). The second way was through control of the curriculum. A national curriculum was introduced, which carefully prescribed what was to be taught and emphasised concentration mainly on Maths, Science and English.

Changes in the source of power over schools' organisation and the curriculum made coherent planning of health promotion in the setting difficult. Local authorities had

developed- sometimes quite extensively- advisory services for schools under their control. These offered support for teachers implementing curricula- for example. through the provision of in service training (INSET). Frequently this kind of help was available for personal, social and health education (PSHE) programmes; many PSHE advisory posts had been created in local education authorities (LEAs) through finance for HIV and drugs prevention. But 'opted out' schools, with greater financial freedom and no direct line of accountability to the LEA, had no obligation to 'buy in' to such services. Many might not have felt they wanted to do so because of the nature of the National Curriculum. This viewed PSHE as a 'cross curricular theme' rather than a subject with protected curriculum time (NATIONAL CURRICULUM COUNCIL, 1990). The importance given to PSHE within particular schools depended to a large extent on the interest and commitment of individual teachers. Even if a teacher was committed, it might be difficult to get a head's endorsement (in the case of 'opted out' schools) to 'buy in' advisory teacher help. It was much more likely to go to examined core curriculum subjects such as Maths and Science; a school's success in attracting pupils (and therefore more funding) depended on success in examination 'league tables'.

All schools- and not just those which had 'opted out'- were affected by the impact of educational reform on their actual or potential health promotion activity. LEAs found it harder and harder to sustain advisory services; and where they did they tended to focus on what the market wanted. Generally, this was support for core curriculum subjects. A weakened advisory service affected every school in the area it served. The National Curriculum (with its capacity to 'squeeze out' health promotion) was of course to be implemented in all state schools, regardless of their organisational status.

## 5. 'The Third Way'?: Health Promotion in the 'New' Political Context

An account of the development of health promotion through the 1980s and into the 1990s seems to be characterised by dispute and paradox. There was sustained disagreement about the nature of health promotion and what it should be attempting to do. Paradox existed in many policy decisions and directions: for example, the neglect of inequalities at a time when the empirical evidence for seeing them as essential determinants of health had never been stronger; and the focus on 'medical model' health promotion (for example in the primary health care setting) when the previously almost mystical power of medicine was being challenged in a very effective way.

Health promotion was certainly developing, but within strong constraints and limitations, including theoretical confusion and political ambiguity or even hostility. It has been argued that the pinnacle of British health improvement policy in the second half of the 20th century- 'The Health of the Nation' (together with related Welsh, Scottish and Northern Irish documents)- marked the high point of the dominance of the medical model of health promotion, with focus very much on disease prevention and individual lifestyle (TONES, 1993: 127).

Health promotion- as this history also demonstrates- is an intensely political activity. Its practice cannot be divorced from the political environment in which it takes place. This observation is one of the starting points for my enquiry into the field's moral problems. As Easton (1953) notes, however, political policy is dynamic. Policies change over time. New policy making regimes replace those that have run their course. In the UK during the 1990s, there were effectively two 'regime' changes with consequent policy shifts and implications for health promotion.

The first was the Conservative party's removal of Mrs Thatcher, and her replacement by John Major. There was a widespread feeling among the party in the very early 1990s that the need for the acute ideology of the former had ended (COLE, 1995): and a period of greater pragmatism was required. It is true that in broad terms the policy of the Thatcherite era towards public services largely continued under Mr Major. However, there were some changes including- in the dying days of the Conservatives' 18- year rule- a greater willingness than before to consider links between social circumstance and individual health. Carefully referred to as 'variations in health', a sub- group of the Chief Medical Officer's 'Health of the Nation' Working Group' produced a report on the impact of what others talked about as inequalities (DEPARTMENT OF HEALTH, 1995c).

Mr Major's Conservative regime was replaced, following a spectacular election victory in May 1997, by a Labour government. This had come to power on a manifesto promising both economic prudence and a commitment to 'restoring' public services like education and health. Its pre- election policy document on the NHS was rich in rhetoric:

'A truly *national* health service no longer exists. It has been replaced by a health market led by accountants, a patchwork of businesses competing with each other, dependent for their funding, and their very existence, on their success in winning orders and making money.... The values that underpin the NHS- a comprehensive health service, free at the point of use, based on need, not the ability to pay- have been betrayed....' (LABOUR PARTY, 1996: 1).

Several months after the election win, important policy documents were produced outlining the future direction of health services and health improvement policy. The first was 'The New NHS' (STATIONERY OFFICE, 1997). This White Paper laid out

government plans for the new organisation of the Health Service. In particular, while it saw continued demarcation between 'commissioners' and 'providers' of health services; it claimed to be getting rid of the internal market through its requirement for collaboration between health service and other organisations. Longer term 'service agreements' were to replace 'contracts'. Primary health care would be the focus for commissioning, through Primary Care Groups (PCGs). These were to be groups of general practices working together to commission services for the population they served, with input to this process from community and local authority representatives. There would be new mechanisms for gathering and disseminating information on effective clinical practice; and a Commission for Health Improvement would have the power to step in and take control of health services failing to deliver effective and efficient services.

'The New NHS' was followed by a consultation (Green) paper on health improvement for England, 'Our Healthier Nation' (SECRETARY OF STATE FOR HEALTH, 1998); and similar documents for Scotland, Wales and Northern Ireland (NORTHERN IRELAND OFFICE, 1998: SCOTTISH OFFICE, 1998; WELSH OFFICE, 1998). 'Our Healthier Nation' and its equivalents were markedly different from 'The Health of the Nation' (and its equivalents) in a number of ways. 'Our Healthier Nation', particularly, proposed a much smaller range of health 'targets', based on the four key areas of coronary heart disease and stroke: mental health; accidents; and cancers. It explicitly acknowledged, and encouraged awareness of, social determinants of health and the persistence of inequalities. Emerging from this, it proposed that individuals, communities and government all had responsibilities and a part to play in promoting and improving health:

'To help bring the nation together in a concerted and co-ordinated drive against poor health, the government proposes **a national contract for health**. The contract sets out our mutual responsibilities for improving health in the areas where we can make

most progress towards our overall aims of reducing the numbers of early deaths, increasing the length of our healthy lives and tackling inequalities in health....' (SECRETARY OF STATE FOR HEALTH, 1998: 29).

Both 'The New NHS' , 'Our Healthier Nation' and its equivalents for the other countries of the United Kingdom were representative of the much vaunted policy approach of the 'Third Way'. 'New' Labour was separated by 18 years from the last Labour administration, which had been severely tainted by a long period of industrial unrest and deeply unsatisfactory economic performance. Public perception was that this administration had been powerless to do anything about the gloomy state in which the UK found itself in 1979 (COLE, 1995). Determined not to succumb to this sort of perception again, 'New' Labour rejected the old creeds of collectivism, monolithic state provision and acquiescence to union power. Equally, however, it did not accept Thatcherite libertarianism. The 'Third Way' sought a distinctive direction that was neither altogether libertarian; nor altogether collectivist (KAY, 1998).

What does the 'Third Way' mean for health promotion? Given that many health promotion practitioners work in or from the NHS, 'Third Way' principles applied to Health Service organisation are clearly relevant. These revolve (at least in rhetorical terms) around establishment or strengthening structures to promote and ensure effectiveness (not simply conceived of as cost- effectiveness); and consumer centredness. In terms of health improvement strategy and the direction of health promotion, the attempt to recognise the limits of both individual and state responsibility for health is probably of most importance in defining the difference of the 'Third Way' (PINTUS, 1998); along with a reinvigorated approach to partnership for health (DARK, 1998).

It could be suggested that this new policy direction is a support to the reconciling of separate perspectives on the nature of health (on the one hand, the view that it is

determined by individuals; and on the other, that it is determined by structures). This history has identified these separate perspectives as being principal causes of the disagreement and dissension strongly characterising my account. I will later argue that they are also intimately connected to moral difficulties emerging from the theory and practice of health promotion. Whether reconciliation of the perspectives (as the 'Third Way' appears to try and propose) is in fact possible- and whether this can contribute to our ability to deal with ethical problems in the field- will also be discussed. For the moment, it is necessary to note the promise for health promotion contained by 'Our Healthier Nation' and related documents- the 'New' Labour government was, after all, the first explicitly to set out its hopes for health improvement within months of taking office. But it is also necessary to note the difficulties. These range from practitioners facing yet further organisational turmoil (HEALTH SERVICE JOURNAL, 1997); through to problems in transforming the new commissioning engine of primary health care to one with a genuinely public health (as opposed to treatment and care) perspective (PECKHAM, TURTON AND TAYLOR, 1998).

## 6. Conclusion

In this chapter, I have considered the first four of my 'dimensions' of a history of health promotion: the history of the social and political context in which it emerged and has taken place; the history of epidemiology and disease control, with which it is strongly connected; the account of the debate about what health promotion is and what it entails; and of its development in particular 'settings'.

In reviewing these historical dimensions, it will already be clear that the field and its nature is both highly disputed; and subject to the demands of public policy and other expressions of value. I now move to consider the fifth and final dimension of my

history- an account of the way in which health promotion has developed as a 'professional activity'.

# CHAPTER THREE- OCCUPATIONAL AND PROFESSIONAL DEVELOPMENT IN HEALTH PROMOTION: THE FIFTH HISTORICAL 'DIMENSION'

## 1. Introduction

In this chapter, I consider what I am calling the 'fifth dimension' of a history of health promotion. This is the account of health promotion's development as an occupational activity.

To introduce this account, I return to the distinction I made in Chapter One. This is between health promotion specialists (HPSs- those whose occupational role is mainly or wholly the promotion of health); and health promoters (those who promote health **as part of** another occupational or professional role- for example, doctors or nurses). Here I sketch out key aspects of the history of the development of health promotion as an occupational activity for both of these groups. I particularly focus on the last 20 years or so.

Such a focus is deliberate. For about this period, a number of those within the occupation of specialist health promotion have been pursuing what I term a 'professionalisation project'. They have been attempting to turn their occupation into a profession. Health promoters- already part of another occupation (or profession)- have not been actively engaged in the project of professionalising specialist health promotion.

This distinctive difference between health promotion specialists and health promoters makes it possible to identify two different accounts within the broad historical dimension of health promotion's development as an occupational activity. There is an account to be given of the 'professionalisation project' (directly involving only health

promotion specialists); and also one to be given of how other occupational or professional groups have developed their health promotion role. Of course, there are connections between the two. This must be so, given that both specialists and health promoters have the common purpose of promoting health (albeit with the major caveat that what this actually means might be understood between and within the groups in different ways). However, the separate accounts of health promotion's development as an occupational activity can be related to important conceptual distinctions that it is necessary to make when exploring the territory of occupational development:

* The term **profession** is both descriptive as well as one carrying ideological connotations (HOYLE, 1980; ERAUT, 1994). **Professionalisation** is the process by which members of an occupational group attempt to take on the values and attributes of a profession in order that they become members of a 'new' profession. An occupational group aspiring to become a profession might conceive of things like formal training, regulation of entry and development and protection of specialist knowledge as descriptive components supporting their aspirations. The activities of some in the occupational group of health promotion specialist can be understood through this conceptualisation.

* **Professional development** constitutes processes through which the skills and expertise required to practice and to improve service to clients are developed (HOYLE AND JOHN, 1995). It is clear that health promotion specialists will be interested in professional development: for some (but not necessarily for all, as my history will show), this interest will connect to the desire to professionalise. But given- as I showed in Chapter Two- there has been over time a growing policy and public interest in health promotion; health promoters are also likely to have interest in professional development in this field.

So there are practical distinctions to be made between the interests of health promotion specialists and health promoters in relation to the broad area of occupational development; and these are connected to important conceptual distinctions. As I will later argue (in Chapter Eight), such practical and conceptual distinctions have importance for attempts to strengthen, in a moral sense, the field of health promotion. Thus both because the story of the 'professionalisation project' and the story of professional development can to some extent be regarded as different: and because that difference possesses ethical import; I have structured this chapter in a particular way.

I begin by describing and discussing the history of specialist health promotion's 'professionalisation project', ending this with an impression of how the occupation was left in the early to mid- 1990s (my historical 'cut off' point, as I discussed in Chapter One). I then move to consider particularly the recent history of professional development for health promotion. Again, it should be noted that this structure is at least to some extent artefactual. There are, as I have remarked, connections between the 'professionalisation project' and professional development in health promotion. Nevertheless, the differences- and their importance for my enquiry later on- warrant the way in which I have chosen to tell the story of the development of health promotion as occupational activity.

## 2. Specialist Health Promotion's 'Professionalisation Project'

Health education and health promotion, I have already argued, possess relatively long (even if not very well recognised or adequately charted) histories. It is only in fairly recent times (from about the 1950s onwards, as already noted) that the sort of role or occupation now thought of as **specialist** in these fields of activity started to emerge.

The 'professionalisation project' of specialist health promotion can only be clearly charted for an even shorter period- from about the end of the 1970s and the beginning of the 1980s. In Chapter Two, a number of historical landmarks in the post- war UK development of health education and health promotion were noted. These included the Cohen Report (MINISTRY OF HEALTH, 1964) which proposed the development of limited structures to carry forward specialist health education at both local and national level. It was imagined this would consolidate and strengthen the capacity of the literally tiny numbers of people who had been employed as health education officers by local authorities since the 1950s; and of the fragile national Central Council for Health Education (CCHE) (BLYTHE, 1986). In fact, the CCHE was replaced by the Health Education Council (HEC) in 1968. In 1976, the Labour government of the day published what might be regarded as the first statement of health education policy and strategy intent (albeit with well- recognised major flaws). This was 'Prevention and Health: Everybody's Business' (DEPARTMENT OF HEALTH AND SOCIAL SECURITY, 1976).

These and other landmarks helped quicken the pace of development of specialist health education services. By the early 1970s, a significant number of areas within the UK had access to specialist health education resources of one sort or another, even though services and activities (from a retrospective point of view) appear quite limited. In 1970-71, there were still only 91 specialist health education officers (HEOs) in post (SUTHERLAND, 1987: 52), still mostly employed by local authorities. HEOs in local authorities were under the control of Medical Officers of Health (later to become community physicians) who in theory had a quasi- public health role and a limited degree of strategic and policy influence (FRENCH, UNPUBLISHED). The role of the HEO at this time seems to have been one of supplying leaflets, giving talks and organising local health education campaigns (EWLES, 1993).

The 1974 NHS Act effectively removed operational health services from local authority control. HEOs, along with community health services and community physicians, moved to NHS Area Health Authorities, becoming part of the same organisation that controlled hospital and acute health services. This was the English situation, with degrees of difference in other UK countries (HAM, 1985).

As already discussed in Chapter Two, the mid- 1970s also witnessed the supposed 'birth' of health promotion with the landmark document of Lalonde (1974) followed by a string of declarations from the World Health Organisation running well into the 1980s (WORLD HEALTH ORGANISATION, 1977: 1978; 1985; 1986). This period saw many health education officers and the departments in which they worked involved in switching their titles to reflect the growing importance (at least in a rhetorical sense) of the 'novel' concept of health promotion. Thus a health education officer became a health promotion officer or health promotion specialist (HPS); and the department where she or he worked a health promotion department. Whether, however, this signified changes in roles and responsibilities wasn't clear (FRENCH, 1985).

The advent of the 'new' movement of health promotion and its eager welcome by some in the UK probably did little to strengthen the organisational position of specialist services or increase resources to them. It could, after all, be seen as a 'reform movement' (YEO, 1993), wishing to change structures as well as (or possibly even more than) individuals. This idea was likely to be anathema to what was now a Conservative government committed to thorough- going economic and social reform, but through a philosophy of libertarianism rather than one of state intervention. However, from the mid 1980s onwards, this government became increasingly concerned about HIV and AIDS. It was this threat from disease which prompted relatively massive increases in resources to health promotion departments at about this time.

HIV infection and AIDS had originally been thought of as homosexual- specific disease. By 1986, though, it was clear that the general population was at risk; it seemed that HIV could be spread through contaminated blood and blood products, as well as through sexual contact (BERRIDGE, 1996a). There was neither cure nor the prospect of one, forcing the government to put its trust in prevention and health education. On the back of 'ring- fenced' finance for HIV prevention (LEATHARD, 1990), many local health promotion departments slowly expanded. At English national level, the HEC became the Health Education Authority (HEA), with a brief for nation-wide co-ordination of public education, although this move to greater governmental control was largely due to lack of trust (BERRIDGE, 1996 (b): TOWNSEND, DAVIDSON AND WHITEHEAD, 1988).)

By the mid- 1980s there were probably about 500-1000 people working in HPS roles. Here was a gathering- and still developing- 'critical mass' of individuals concerned to define and develop their occupational role further. For some of these at least the idea of professionalisation would have appeared attractive. Lawn (1996) argues that if a project of professionalisation is to be successful, the professionalising occupation requires a grouping- an association or organisation- to carry forward its claims and represent itself to the public as worthy of performing its occupational function. For HPSs, this was the Society of Health Education Officers (SHEO), later to become the Society of Health Education and Health Promotion Specialists (SHEPS). The Society can be seen as both the principal representative of, and the main force behind, the HPS 'professionalisation project'. Its function in these respects has, however, been weakened by the fact that during this history it has never had any more than between a quarter and a third of HPSs in membership. In 1996, for example, there were only 350 members of SHEPS (SOCIETY OF HEALTH EDUCATION AND HEALTH PROMOTION SPECIALISTS, 1998c). Further, as will be seen, even the minority of

HPSs actually in membership of the Society did not unanimously hold the view that the project was a legitimate one.

From the early to mid 1980s onwards, professionalisers within the Society tried to move the project forward in three main kinds of ways: through development and agreement on a code of conduct for HPSs; through construction and maintenance of a professional register of specialists; and through encouragement and promotion of appropriate education and training for the occupational group. These can all clearly be seen as descriptive elements of a profession, things likely to be important to professionalisers (ERAUT, 1994: HOYLE, 1980)

Work on the code of conduct and the professional register was begun by the Society's Code of Conduct sub- committee in the early 1980s. The first version of the code appeared in 1985 (SOCIETY OF HEALTH EDUCATION OFFICERS, 1985). Progress with the idea of the professional register appears to have been much slower, with no record of any important development and a register only finally being published in 1991 (SOCIETY OF HEALTH EDUCATION AND HEALTH PROMOTION SPECIALISTS, 1991).

Plans to encourage, promote and possibly control access to appropriate education and training had begun against the background of a report from the National Staff Committee for NHS Administrative and Clerical Staff (1981). 'The Recruitment, Training and Development of Health Education Officers' (better known as The Kirby Report) recommended that the postgraduate diploma in health education be adopted as providing the basic education and training for HEOs. (Postgraduate training in health education had begun at London's Institute of Education in 1954, although diploma courses recognisable to those familiar with current provision did not begin to emerge until 1971 (Leeds Polytechnic), followed in 1974 by South Bank Polytechnic

and, in the early 1980s, by Bristol Polytechnic.) The Society established an education and training sub-committee to monitor and contribute to these developments.

This impression of gathering pace in the 'professionalisation project' is not just attributable to the presence, for the first time, of a sufficient 'critical mass' of those engaged in the occupation. Arguably it is also due to events at the time in the NHS, which still employed by far the greatest number of HPSs. The mid- 1980s saw the Health Service undergoing profound change. Before the Conservatives' election in 1979 under Margaret Thatcher, there had been broad political consensus on the NHS, with the view that it was acceptable for it to be an **administered** service. But early in the 1980s, Sir Roy Griffiths (of the Sainsbury supermarket chain) was asked to chair an enquiry into Health Service management. The introduction to his 1983 report is now famous:

' "If Florence Nightingale were carrying her lamp through the corridors of the NHS today.... she would almost certainly be searching for the people in charge"....' (TIMMINS, 1996: 409).

The report recommended shifting the NHS to **managerial** accountability. Recommendations took less than two years to implement (LEATHARD, 1990). Within this time scale the Service had moved, at least in theory, from being one where professional autonomy was unchallenged, to one concerned with control, quality standards and performance indicators, applied by general managers. For HPSs, this was likely to have been a worrying time. They possessed little in the way of 'professional' status and were therefore more vulnerable than many other groups to the wind of managerial change.

A policy workshop held in Harrogate in February 1988 provided a further focus and impetus for the 'professionalisation project'. Sponsored by the HEA and organised by

the Society, the preface to the workshop report clearly marks it out as an attempt to capitalise on the times (this was the period when HIV prevention monies were in full flow):

'Recent developments in the National Health Service, the rapid increase in the expansion of health education knowledge and practice, and the firming up of health education theory has created a more urgent need for review and reappraisal than ever before....' (SOCIETY OF HEALTH EDUCATION OFFICERS, 1988).

The outcome of the workshop was a plan for 'professionalisation' centred around three strongly connected areas: registration; recruitment (together with linked subjects such as education and training); and the maintenance and development of standards for professional practice. The agenda sounds very much like the one pursued by the Society from the beginning of the 1980s. The difference lies in the fact that the connection between the areas was more strongly emphasised; and there was now official 'sponsorship' (by the HEA) for the project.

The workshop proposed that a register of HPSs should be established, with those eligible to appear on the register having to fulfil certain criteria such as possession of appropriate qualifications, levels of experience and skills. Educational provision for postgraduate training and qualification in health education and health promotion would be supported (at this time, provision was confined mainly to a handful of institutions offering the postgraduate diploma qualification). Those already within or planning to enter the occupation of HPS would be encouraged to seek postgraduate qualification. The appropriateness and quality of courses offered would be monitored and a validation or accreditation system for these would be introduced. Eventually, possession of a postgraduate qualification from an institution accredited by the Society would be part of the requirement for registration; practice would be contingent on registration. Registered practitioners would have a duty to adhere to the

principles and articles to be set out in a new code of conduct. This programme of 'professionalisation' was accepted by Society members at its Annual General Meeting in April 1988.

In 1989, the Society published a document committing itself to the implementation of a formal registration scheme for HPSs and outlining in more detail how this might function (SOCIETY OF HEALTH EDUCATION AND HEALTH PROMOTION OFFICERS, 1989). This was probably the catalyst to the most explicit expression of anti- professionalisation sentiment yet identified. A small number of practitioners wrote an open letter to the HPS community arguing that professionalisation was likely to restrict the benefits brought by the diversity of skills and experience to be found in the range of people entering the occupation:

'We believe that health education benefits from this diversity, and this will be discouraged or prevented by the introduction of standardised formal requirements and registration....' (CHAND, TILSTON AND VERRALL, 1989).

Underlying this and similar statements is deep ideological unease on the part of some involved in the occupation. This unease can be detected right the way through the history of the 'professionalisation project'. If entry to the practice of health education and health promotion is restricted, this could be seen as a betrayal of principles of empowerment, a conceptual and practical cornerstone of the fields of activity. For some, professionalising was tantamount to removing the philosophy and purpose of health education and health promotion.

There seems to have been little response to this open letter. Recruitment to the Society neither dramatically increased nor declined now that it was explicitly committed to professionalisation. This can reasonably be interpreted as lack of

interest among the majority of members of the occupation, while relatively few were actively for or against the project.

This lack of interest is apparent through much of the remainder of the project's history. The Harrogate programme of registration, education and training, and professional standards was carried forward by three Society sub- committees.

The Membership and Registration sub- committee eventually produced a 'Register of Health Education and Health Promotion Specialists' (SOCIETY OF HEALTH EDUCATION AND HEALTH PROMOTION SPECIALISTS, 1991). The Register was a symbol of unhappy compromise in the debate about education and training and authority to practice. Relatively few HPSs possessed postgraduate qualification in health education and health promotion. Many more were practising without such qualification but with skills and experience deemed appropriate for the work. All these people- whether possessing a 'formal' qualification or not- were allowed to appear on the Register. Thus it failed to create any kind of seal between training and practice. Importantly, in terms of the Harrogate plan, publication of the Register was not accompanied by a commitment to ensure that an individual's inclusion in future depended on their possessing postgraduate qualification.

Another Society sub- committee worked on the issue of education and training. Criteria were established for the validation of academic postgraduate courses in health education and health promotion. These criteria related to such things as admission policy, health promotion background of teaching staff, links between the practice and academic settings and so forth. The number of courses recognised increased incrementally. By 1997, 26 postgraduate courses were Society- validated (SOCIETY OF HEALTH EDUCATION AND HEALTH PROMOTION SPECIALISTS, 1997d).

Once again, however, this work faced difficulties, particularly when seen as part of a strategy for professionalisation. Courses were developed by individual higher education institutions; there was no national guidance or direction (from the Society or any other body) as to what learning they should try to deliver. Combined anyway with uncertainty and dispute about the nature and content of knowledge in health promotion (RAWSON, 1992), the result was that provision varied, sometimes markedly, between institutions (BREMNER, 1994: COTTER, 1994). Coherent and nationally agreed provision looked impossible to achieve. This meant that even if it was possible to assert that ability to practice should be contingent on registration linked to training, this was likely to be followed by difficult questions. What training? To be offered by whom?

The final component of the Harrogate programme was the maintenance and development of standards for professional practice. This issue was addressed by the Code of Conduct committee, which had now become the Standing Committee on Professional Practice (and was later to change its name again to the Standing Committee on **Principles** of Practice). Its key task was revision of the Society's Code of Professional Conduct and Principles of Practice, which had first appeared in 1985.

Towards the end of 1989, however, the wider background was further, and dramatically, coloured. A slowly unfurling crisis of funding in the NHS had reached its peak (at least in terms of media attention) during the previous winter and had prompted government plans for reform of the Service, far beyond the scope even of the Griffiths Report. The White Paper, 'Working for Patients' (DEPARTMENT OF HEALTH, 1989) described legislation eventually introduced as the National Health Service Act 1990 (DEPARTMENT OF HEALTH, 1990). This created an 'internal' or quasi- market in health care, within which 'purchasers' (health authorities and some general practices) bought services from 'providers' (usually NHS hospital or community trusts).

The reforms were radical in conception and execution, although probably not as radical as the prime minister of the time, Margaret Thatcher, would have liked (COLE, 1995). Their purpose was to transform previously hierarchical relationships into those of the market place, primarily through the mechanism of contracts for services. They were, of course, driven by the Conservative Party's continuing ideology of economic liberalism. Opponents of such ideology had no trouble in painting a bleak picture of the road down which the reforms would lead:

'Access to doctors and hospitals will become increasingly dependent upon the general health of the catchment area in which one lives, the policy of one's GP and his or her skill in negotiating contracts with "providers". Inequality in health provision will become more marked, and the health of the poor will become worse....' (HUTTON, 1995: 213).

This sort of view might have especially alarmed HPSs, for two reasons. First, where was the place for the often vague and frequently unquantifiable 'health promotion' in a market place likely by definition to be interested in tangible goods? Second, even if 'health promotion' was something in which the market was interested, where was the place for specialist health promotion services? Did they belong with 'purchaser' or with 'provider'? Despite some strategic work (SMITH, 1993) and much practitioner thought, this question was never satisfactorily answered.

Against this rapidly changing and arguably hostile background, the Principles of Practice Committee consulted with SHEPS membership on revision of the Code of Conduct (PRINCIPLES OF PRACTICE COMMITTEE, 1992; SOCIETY OF HEALTH EDUCATION AND HEALTH PROMOTION SPECIALISTS, 1992). The revised Code and Principles of Practice were eventually published in 1993 and revised again in 1997 (SOCIETY OF HEALTH EDUCATION AND HEALTH

PROMOTION SPECIALISTS, 1993: 1997b). The difficulty, however, was that the Code was only one part of the programme for professionalisation which had emerged from Harrogate back in 1988. Without mandatory registration contingent on practice, linked to accepted qualifications, it was essentially a 'toothless tiger'.

The idea of mandatory registration was as far away from realisation as ever. The Registration Committee consulted with SHEPS membership over the issue during 1992-3, having identified two possible routes to the goal: parliamentary (or primary) legislation; and regulation through the Secretary of State for Health (secondary legislation) (FAGGE, 1993). A ballot on whether to continue investigating the issue of mandatory registration was held among SHEPS members in early 1995. From a membership of 450, the turnout was 35.4%, with 60.6% (about 95 members) in favour of continued investigation.

It was hard to interpret this result as representing anything other than widespread lack of interest. The Registration Committee continued its explorations, but in July 1996, under the heading 'Mandatory Registration on Hold', the SHEPS Newsletter made the following announcement:

'Following last year's mandate from the membership to continue looking at the possibility of establishing a mandatory registration scheme for health promotion specialists, the Executive Council has now voted to indefinitely delay any further action. Following discussions with the Department of Health and other organisations over the issue the possibilities for further progress were seen to be very limited. It was decided therefore that the Membership and Registration Standing Committee's priority for work over the coming year shift to building the membership of SHEPS....' (SOCIETY OF HEALTH EDUCATION AND HEALTH PROMOTION SPECIALISTS, 1996: 3).

Two issues need to be considered in the interpretation of this decision. The first, as already mentioned, is the evident lack of interest in mandatory registration (for which read a fundamental part of the 'professionalisation project') on the part of many HPSs. The second is the realisation on the part of the SHEPS leadership that the Department of Health- driven by a Conservative government intent (to some degree) on limiting and diminishing professional power- was hardly likely to be supportive of attempts to create a 'new profession'.

This decision by SHEPS effectively to abandon its explicit 'professionalisation project' (at least as this was conceived from the mid to late 1980s onwards) was made almost at the provisional 'cut off' point for history which I discussed in Chapter One. However, it is worth briefly describing what has happened since 1996. The change of political landscape in 1997, following the election of the New Labour government, has not led to an alteration in the SHEPS position on the pursuit of registration and professionalisation. A discussion paper produced almost immediately after the election did not even mention these issues (SOCIETY OF HEALTH EDUCATION AND HEALTH PROMOTION SPECIALISTS, 1997c).

Arguably this was in part because- despite key differences in style and substance over many policy matters (including health) between the old and new governments- Labour was as dubious about 'professionalisation' as the Conservatives. Proposals for Health Service reforms (DEPARTMENT OF HEALTH, 1998) contained strong elements of even greater requirements of accountability on professions, in particular clinical accountability. These followed in part from a number of prominent scandals which reached public attention in the last days of the Conservative government- especially the so-called Bristol Heart Babies affair (HEALTH SERVICE JOURNAL, 1999b; HILL, 1999).

Further, the new government's agenda for health represented a relatively radical shift from the 'medical model' to something more akin to a 'social model', with far greater recognition of the possible range of influences on health beyond individual lifestyle (SECRETARY OF STATE FOR HEALTH, 1998). This has led to the view that there is at least the possibility of new roles being required to meet this new agenda. In particular, attempts seem to be emerging to re- define (and support) the role of 'public health specialist' (DENT, 1999). Exactly what this means, for who, and where, is beyond the scope of this thesis. What is clear is that continuing shifts in roles and responsibilities, and continuing political scepticism, combine to create an enormously difficult climate for any kind of 'professionalisation project' for specialist health promotion.

## 3. The Professionalising Occupation of Specialist Health Promotion: Snapshot of a 'Moment in Time'

By now it will be clear that the history of specialist health promotion's 'professionalisation project' contains as much dispute and ambiguity as the other historical dimensions discussed in Chapter Two. In the following chapter, I argue that this dispute and ambiguity relates centrally to values. As such, health promotion is an intensely problematic field in a moral sense. In Chapter Six, I 'listen' to a number of practitioner 'voices' who confirm this analysis; before attempting to seek ways of understanding, in Chapter Seven and Chapter Eight, how health promotion might be morally 'reconstructed'. One way I explore is whether it might be possible to conceive of health promotion as a moral 'profession'. Although my argument at this stage is basically theoretical, it is informed by my understanding of the place of health promotion in the UK context; and by the understanding of the practitioners to whom I have been 'listening'.

These practitioners were sharing their understanding with me during the mid- 1990s. If this understanding underpins argument on the nature of health promotion as a 'moral profession', it is important to be clear about how that 'profession' appeared at the time the practitioners were forming their perceptions. What was the nature of the occupation (the embryonic profession) of specialist health promotion in the mid-1990s? The following is a snapshot that might have been taken during this time.

By far the largest number of HPSs were employed within the NHS. Before the Health Service reforms of 1990, specialists generally worked in health promotion units (HPUs), which were located in almost all of the health authorities in England and Wales, health boards in Scotland and health and social services departments in Northern Ireland. By and large, HPUs undertook the kind of unified health promotion planning, enabling and supporting role I described in Chapter One (with greater or lesser emphasis on parts of that role according to local influence and interest). Organisationally, they tended to be part of either the public health directorate or community unit of the health authority.

As already discussed, the 1990 reforms split the Health Service into 'purchasers' on the one hand, and 'providers' on the other. From survey work undertaken during the summer of 1993, Adams (1993) identified 36% of responding United Kingdom (UK) HPUs as purchasers, 38% as providers and 22% as having been 'split' in some way to perform both functions. (The extent to which the survey elicited responses from all UK HPUs is not clear, partly because of the organisational confusion existing at the time.) Generally speaking, those identified as purchasers were managed within the public health directorates of health authorities; those as providers were within NHS community trusts. Health promotion managers (those running HPUs) were accountable themselves to a range of others, including directors of public health, chief executives of health authorities or trusts and directors of nursing.

It has been notoriously difficult to define what exactly ' purchasing' and 'providing'. health promotion constitutes (ADAMS, 1993: SMITH, 1993). Adams, in the summary of her 1993 survey, writes:

'Many health promotion specialists do not feel that health promotion fits the purchasing and providing model. Whilst undertaking health promotion is part of many health workers' roles, a health promotion *specialist* function is just that. It is a strategic, catalytic, advisory and consultancy function, concerned with district- wide programmes, healthy alliances, healthy public policy....' (ADAMS, 1993: 4).

In practice, although it is hard to discover documentary evidence, it is likely that there was greater or lesser emphasis on components of this unified function depending on where HPSs were organisationally located. For example, a HPS working within a purchasing health authority was likely to have a role more focused on needs assessment and policy formation; while one working for a provider trust was probably more concerned with implementing and managing programmes.

Adams' work draws out a number of additional features of the form and function of specialist health promotion at this time. Respondents suggested that the ability to work in strategic and multidisciplinary ways was being eroded by the growing sense of competition between, for example, separate NHS Trusts. Specialist health promotion services were increasingly being managed, at a remove, by people with neither experience nor formal training in the occupation. The significant relationship between public health and health promotion functions was often good but sometimes undermined by feelings of 'threat' or lack of equality (ADAMS, 1993: 24).

In summary, a snapshot of specialist health promotion at this time shows an occupation divided by the NHS reforms. The division is both in terms of organisational position; and practical function. It appears to be adversely affected by

the themes of competition and deregulation dominating the Service at this point in its history. In this context, as already discussed in the previous section, a small number of the occupational group are attempting to implement a 'professionalisation project' with its particular components of mandatory registration, formal training and the development of professional standards. Others in the occupational group believe that this project militates against the purpose and principles of health promotion. In any case, the context- particularly of deregulation and competition- appears directly to contradict the project. The overall impression, from this snapshot of the occupation in the early to mid- 1990s, is of lack of unity, fragmentation and a consequent sense of threat. Such a picture needs to be carried to Chapter Eight and considerations of whether and how the 'profession' of health promotion can be strengthened as part of a moral reconstruction of the field.

**4. Courses, Competences and Qualifications: Professional Development and the Health Promoter**

My concern now is briefly to chart the recent history of professional development for health promoters as the second part of a survey of how the occupational activity of health promotion has developed. As I have made clear, the distinction between the history of the 'professionalisation project' and professional development is somewhat artefactual. Certainly it would be a mistake to regard them as being completely divorced from each other. 'Professionalisers' were interested in professional development; and those involved in professional development, but not health promotion specialists, may well have had an interest in the 'professionalisation project'. Nevertheless, the distinction is important enough conceptually and practically- particularly as I advance towards moral arguments for 'professions'- to justify progression through history in this way. Having given an account of attempts to professionalise specialist health promotion; I move to a brief sketching of

professional development for those engaged as part of their role in health promotion activity- health promoters.

Almost any occupational or professional group could be seen as having a health promotion role; and therefore might possess a history of professional development in relation to this field. Attempts at a comprehensive history, then, might be both time-consuming and, in the end, too vague or diffuse. For this reason, I have chosen to focus my account on professional development for two key professions whose practitioners are likely to have health promotion as part of their role- medicine and nursing. This is partly because attitudes towards health promotion on the part of these professional groups are enormously important for the field of activity; and partly because the nature of their relationship to health promotion has important implications for later theoretical arguments I make. Towards the end of this section, I will also discuss the recent history of the development of national occupational standards (NOS) for health promotion. If it is agreed that NOSs generally describe what needs to happen in employment (MITCHELL, HARVEY AND ROLLS, 1998); it can be argued that the history of standards development for health promotion is likely to influence the practice in this area of a range of occupational groups.

To begin with the recent history of professional development for health promotion in the profession of medicine. Conceptions of the nature, purpose and relative importance of components of medical education were dramatically changed by the seminal 'Tomorrow's Doctors' (GENERAL MEDICAL COUNCIL, 1993). This set out to establish in detail what it was reasonable to expect a medical practitioner to be able to do. An important expectation was the contribution of doctors to illness prevention and health promotion. The General Medical Council (GMC) proposed opportunities in undergraduate medical education to develop understanding of the principles and methods of health promotion; and of skills related to the promotion of health (for example, information giving, counselling and risk assessment). The GMC

also proposed a re-orientation of medical educational processes away from concentration on 'facts learning' to the encouragement of critical thinking and personal development; and from bio- mechanical accounts of disease to the development of understanding which put health and illness in their socio- cultural context. If this re- orientation was to be achieved, it too would be likely to be broadly supportive of the development of health promotion in the profession of medicine.

Toon (1998) sees a number of issues emerging from the GMC's direction for medical education. Undergraduate medical education has to provide the basis for a variety of more specific postgraduate vocations (in both acute and primary health care contexts). It may therefore be hard to define a common core of generally required health promotion- related knowledge and skills. He also identifies a tension between the competing goals of medical education. On the one hand, it is to provide a basis for independent practice; on the other, it is to produce safe, competent hospital house officers. Arguably, for those operating in this role it is often hard to see illness related to the social context in which it is produced. Although there are clearly difficulties in developing a place for health promotion at all levels of formal medical education, Harden (1995) and Parle *et al* (1997), among others, write encouragingly about positive trends in this area.

Thinking on the nature and purpose of initial professional education for nurses has in recent times undergone a 'paradigm shift' rather similar to that of medicine and 'Tomorrow's Doctors'. In organisational terms at least, the shift has probably been even more profound. The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) Project 2000 (P2000) moved nurse training from an apprenticeship, 'learning on the job' model to a concurrent system, in which periods of professional practice were built into a higher education diploma level course. P2000 was seen as:

'The means of producing a "knowledgeable do-er". To achieve this, skills of critical analysis and reflection have been seen as crucial....' (RIVERS, AGGLETON AND WHITTY, 1998: 8).

It is clear from considering P2000 that health and wellness promotion is viewed as central to the nursing role. Thus, academics and others in nursing feel able to make statements such as:

'Any [nursing] interaction has the potential to be health promoting....' (LATTER, 1998).

As well as the radical shift in favour of health promotion at the level of initial professional education, the mid- 1980s onward also saw nursing having the benefit of continuing professional development activities with a strong health promotion flavour. These included Health Education Authority (HEA) 'training the trainers' initiatives such as 'Look After Yourself' (LAY) and 'Helping People Change'. Although narrow in focus- concentrating mainly on the development of mechanistic techniques aimed at changing 'risky' individual health behaviour- they have nevertheless encouraged many nursing professionals to become more directly involved in the promotion of health (LAWRENCE, 1999).

It is also the case that courses with a broader focus continued or were developed during this period. An example was 'Promoting Health: Skills, Perspectives and Practice', the product of an educational partnership between the HEA and the Open University (OU) (OPEN UNIVERSITY, 1997). Clearly a primary market for this was the profession of nursing, as successful completion of the course allowed for registration of an award with the UKCC.

The kinds of developments described here give an impression of slowly increasing opportunities for the professional development of nurses with regard to that part of their occupation connected to the promotion of health. The landscape of professional development for all those involved in health promotion has also been changed by recent attempts to describe competence in this field of activity through standards- the so- called National Occupational Standards (NOS).

These Standards are attempts to describe performance- what people are expected to do in employment (MITCHELL, HARVEY AND ROLLS, 1998: 158). They are developed on behalf of an occupational group by that group's Lead Industry Body (LIB). The LIB undertakes a functional mapping of the occupation. This is:

'A process of analysis which defines and delineates the parameters of the occupation or sector by defining the key *purpose* of the sector: identifying the *functions* required to be undertaken by the occupation or sector as a whole, to achieve the key purpose; developing the national occupational standards and competences required to achieve these functions....' (ROLLS, 1995: 12-13).

Once standards have been developed, the LIB, together with an awarding body, puts forward proposals for a qualification based on the standards (and the competences they identify) to the National Council for Vocational Qualifications (NCVQ) and the Scottish Vocational Education Council (ScotVEC). If accepted, a National Vocational Qualification/ Scottish Vocational Qualification (NVQ/ SVQ) related to those competences becomes available.

In 1992, the HEA commissioned a three year 'Competences for Professional Development in Health Education' project. Objectives for the project included the identification of competences for different professional groups involved in health education and health promotion; and the development of methods of competency

measurement and assessment. There was a strong strategic concern on the part of the NHS that Health Service activities should benefit from Standards development and related NVQs/ SVQs (ROLLS, 1995).

When the project was completed, further work was begun (in November 1995) to develop National Occupational Standards for health promotion. This work was explicitly set within the framework of the Department for Education and Employment (DfEE) National Standards Programme (ROLLS, 1995) and carried out under the auspices of the Care Sector Consortium (CSC), the LIB for the health and social care sector.

The Standards were developed by a multidisciplinary group, including health promotion specialists, environmental health, occupational health, nursing, midwifery, social work, complementary medicine and professions allied to medicine (MITCHELL, HARVEY AND ROLLS, 1998). They were eventually published as 'National Occupational Standards for Professional Activity in Health Promotion and Care' (LOCAL GOVERNMENT MANAGEMENT BOARD, 1997). The Standards attempted to describe performance in relation to three broad areas: the foundations of professional activity; the context of professional activity; and a range of particular activities themselves. Within each of these areas are a number of roles against which detailed standards have been developed and described.

Following publication of the Standards, they were 'piloted' at a number of 'test sites' including a university medical school and a postgraduate health promotion course (HEALTH EDUCATION AUTHORITY, 1998a). Results of this exercise were published towards the end of 1998 (HEALTH EDUCATION AUTHORITY, 1998a, 1998b).

There has been a well rehearsed debate about the problems and possibilities with Standards (and related qualifications) in general; and those for health promotion and care in particular. For some, Standards are crude tools, blunt instruments incapable of allowing for the complexities of practice (ELLIOT, 1993). This is an especially problematic criticism for the Standards for Health Promotion and Care, given the deep complexity and disputability of this field of activity, at both conceptual and practical level. At least one professional association, responding to the Health Promotion and Care Standards, has expressed the worry that they will promote 'the generic therapist' (MITCHELL, HARVEY AND ROLLS, 1998: 167). Such a person, possibly attractive to politicians and managers concerned with cost- effectiveness, may be alarming to professions anxious to mark out and maintain their territory. Others, however, have suggested that the applicability and transferability of the Standards between different occupations may promote inter- professional and multidisciplinary collaboration. Against this background of expression of both possibilities and concerns related to the Standards, it is unclear as to whether an infrastructure will be present to support both their development, and that of the framework within which they are operated (MITCHELL, HARVEY AND ROLLS, 1998).

Standards are most frequently and easily regarded as a tool for management- attempts to describe performance expectations. In this sense they are normative. As such, they bear more than a passing similarity to other kinds of normative expression- for example, of moral obligation. In Chapter Seven, I consider some of the problems and possibilities related to attempts to construct a set of moral obligations for those involved in the practice of health promotion. While the language of the National Occupational Standards for Health Promotion and Care might be different from that of moral philosophers attempting to establish obligations for health promotion practitioners; problems and possibilities with both might be more closely connected than imagined. In particular, I will later consider the accusation made against so-

called 'obligation ethics' that it is too blunt an instrument to be used with any reliability, particularly in the complex and ambiguous field of health promotion. This sounds like an echo of the voice, reported above, that has been raised against the National Occupational Standards.

## 5. Coda to the History: The 'Disrupted Tradition' of Health Promotion

I have now reached the end of my account of the five 'dimensions' of a history of health promotion. Both the conceptualisation and recounting of this history pose complex problems. At this stage of my thesis, there are particular difficulties. History telling raises again the questions of what is being discussed here, and where exactly the moral problematic lies. If it does nothing else, analysis of the five 'dimensions' demonstrates profound tensions between competing understandings of- and actions for- 'health promotion' on the part of different people and organisations. For example, some people (a small number of health promotion specialists) have believed that the occupation of specialist health promotion is amenable to 'professionalisation' (arguably the 'protection' of the occupation through mechanisms such as mandatory registration and training). Other have asserted that this conception of the occupation (and thus, in part, of the nature of health promotion) is completely wrong- headed. There are many other instances of opposing 'voices' that I have heard while assembling this history. How is it that such oppositions and differences exist now and have existed for much of certainly the recent history of the field of health promotion?

I suggest that interpretation of the history itself supports an answer to this question. Consider this beginning to Alastair Macintyre's 'After Virtue':

'Imagine that the natural sciences were to suffer the effects of a catastrophe. A series of environmental disasters are blamed by the general public on the scientists.

Widespread riots occur, laboratories are burnt down, physicists are lynched, books and instruments are destroyed. Finally a Know- Nothing political movement takes power and abolishes science teaching in schools and universities, imprisoning the remaining scientists....' (MACINTYRE, 1985: 1).

Macintyre imagines further. He describes the advent of a movement of enlightenment which rebels against the destruction and tries to piece science back together again, although its members have largely forgotten what it was and have only fragments of the past with which to attempt their reconstruction. After great effort, the re-building of science is complete and people in the 'new' world go about making use of it. But what they are doing is not in fact natural science:

'For everything that they do and say conforms to certain canons of consistency and coherence and those contexts which would be needed to make sense of what they are doing have been lost, perhaps irretrievably....' (MACINTYRE, 1985: 1).

Macintyre's imagined world of the destruction and reconstruction of science forms the prelude to the major argument of 'After Virtue'; that morality and its language are in the same disrupted and confused state as the language of science in his fictional scenario. Like science in the story, morality and moral philosophy enjoyed a period of flourishing during which the nature of their construction and purpose were clear. Like science in the imaginary world, these were destroyed and are now reconstructed in damaged form.

I suggest that Macintyre's account of the 'disruption' of morality might be useful in explaining and understanding the history of health promotion. Most straightforward historical accounts of the latter work on the assumption that health **education** has a relatively extensive tradition; while health **promotion** is to all intents and purposes a novel concept. Floating somewhere within them is also the notion of **public health**.

The health education- then- health promotion version of history, as I argued in Chapter Two, is problematic because it fails to take account of much activity that took place during the mid- nineteenth century and whose purpose was protection of the health of the public (albeit for a mixture of political ends, some unrelated to health). If this era is identified at all within accounts, it is as a separate and different phase of 'public health' (ASHTON AND SEYMOUR, 1993). We now have, even more unhelpfully, four possible 'protection of the health of the public'- related concepts with which to grapple: the Victorian phase of public health: the modern phase of public health; health education; and health promotion. I acknowledge the clumsiness of my own phraseology to embrace all four concepts; but my wish at the moment is to avoid using one in particular at the expense of the others.

My argument is this. Activity aimed at protecting the health of the public extends at least from the mid- nineteenth century and embraces both 'Victorian' and 'modern' phases of public health; as well as health education and health promotion. Such activity should therefore be seen as possessing a unified history.

What should this unified history be called? Theorists have usually suggested that health education is a component of health promotion, the latter extending beyond educative processes to include health promoting public policy and protection measures (DOWNIE, TANNAHILL AND TANNAHILL, 1996: EWLES AND SIMNETT, 1992; NAIDOO AND WILLS, 1994; TONES AND TILFORD, 1994). A complete history of activity aimed at protecting the health of the public could not, therefore, be called a history of health education. Could it be called a history of public health? If I stick with my clumsy but encompassing phrase- and also stick with my intention to use others' voices to understand meanings- then it often sounds as if people talking about 'public health' (as distinct from public health medicine) are speaking of a broad range of activity aimed at protecting the health of the public

(ASHTON AND SEYMOUR, 1993: REID, 1999). Equally, though, so does 'health promotion' (consider Downie, Tannahill and Tannahill and the other writers cited above). So my claim for the unified history of activity aimed at protecting the health of the public could be called 'The History of Public Health' ; or 'The History of Health Promotion'. My own preference is to call it the latter, but I can see no reason other than partisanship for this. This would apply to someone making the alternative choice. The central point is that the idea of the unified account should be accepted. If it is not, then we would return to the unhelpfulness of accounts suggesting that the history of health promotion begins round about 1974.

Such accounts are unhelpful because they lack the power to explain the persistent disputes about what health promotion is and what it involves. My suggestion of a unified account, and of the 'disrupted' nature of the history of health promotion as it is frequently presented, claims to offer some insight into these disputes.

Caricaturing the history I have described in this chapter and in Chapter Two, it is possible to suggest that there are two key- and opposing- versions of what is to count as 'authentic health promotion activity'. One is the healthy public policy view of health promotion; and the other is the individual- centred, medical model approach. Each inspires loyalty from different groups and each is disputed, with varying degrees of ferocity, by its opponents. (Of course, this view is highly caricatural. It is possible to have public health policy based on the medical model- for example, 'The Health of the Nation'. It might also be that we have some sympathy with the view of a writer such as Armstrong (1993) who claims that the demand for 'health surveillance' renders public policy and medical model health indistinguishable.)

History- and this interpretation of it- helps to identify the reasons for such dispute. On the one hand, people who adhere to healthy public policy are returning to the historical roots of health promotion, although these are seldom, if ever, identified as

such. On the other hand, people adhering to the medical model are aligning themselves to the individualistic 'health care' approach to health promotion which has profoundly dominated recent times (and which is itself the by-product of an immensely powerful medical tradition concerned with the individual). If health promotion's history is seen as 'disrupted', disputes and differences become more understandable, for the opposing sides can each reasonably see themselves as heir to the 'legitimate' tradition. The difficulty is that the nature of the tradition, and in particular its disrupted character, has not been adequately identified. Developing an understanding of health promotion as a 'disrupted tradition' will be important as I move to presenting proposals for a moral argument in support of the field; and begin substantively to question this.

# CHAPTER FOUR- MORAL ARGUMENTS FOR HEALTH PROMOTION: PROPOSALS AND SCEPTICISM

## 1. Introduction

Dispute about what is meant by health promotion and what kinds of activities it can reasonably be said to involve took up a sizeable amount of my chapters on history. The story told so far will also have made clear that the promotion and improvement of health is at the very least a strong human aspiration stretching back certainly through the twentieth century as well as much of the nineteenth. If the nature of that aspiration, and policies and practices which might support it, are disputed; fertile ground for moral enquiry appears to exist. In this chapter, I begin my enquiry by building up, then critically examining, a 'moral case' for health promotion.

Before this process can be started, however, I need to address the question, 'What is understood by "moral"?' The Concise Oxford Dictionary suggests that 'moral' is:

'Concerned with goodness or badness of character or disposition, or with the distinction between right and wrong....' (OXFORD UNIVERSITY PRESS, 1978).

Lacey agrees with this view, writing that 'moral' is:

'Concerning habits, customs, ways of life, especially when these are assessed as good or bad, right or wrong. Etymologically, the Latin "moral" corresponds to the Greek "ethical". They both mean "concerning habits etc.". Among things we call moral are theories, arguments, outlooks, rules, reasons, men, books, actions, intentions and perhaps desires and feelings....' (LACEY, 1976: 138).

On this etymological basis, then, I use the term 'moral', the associated one of 'morality' and that of 'ethics' interchangeably. A moral enquiry into health promotion thus becomes, seemingly, an enquiry into whether it is good or bad, right or wrong.

At this point, however, I re- encounter a difficulty introduced in Chapter One. What exactly is the 'it' that I am talking about and trying to assess the morality of? Dispute about what the 'it' actually was, and is, characterised my history- writing, as I have said. Is health promotion an idea or a set of activities? Could it be both? If it is a set of activities, what exactly is the nature and character of that set? Despite extensive thought about the character of health promotion through examination of its history, I continue to struggle with these questions.

The dilemmas posed in the first chapter, when I tried provisionally to build an understanding of health promotion, become very pertinent here. Models provide some descriptive sense of health promotion, but essentially- perhaps above all else- they are rooted in values. As I start to build and examine a 'moral case' for health promotion, the problematic becomes acute. If I base my understanding on models, they provide conflicting accounts of 'authentic' action; for example, that conceived according to the medical model as opposed to that according to the empowerment model. Whatever I choose, I could be accused of bias either for or against health promotion's 'moral case'. If, on the other hand, I try to embrace everything that could be regarded as 'health promotion', the subject of my enquiry becomes so general as to be hard to focus on. Further, problems already mentioned such as establishing whether unintentionally health promoting activities should be regarded as health promotion are reinforced. How can I reasonably construct a 'moral case' either for or against health promotion that includes consideration of activities which have no intention of promoting health (but somehow incidentally do)?

There is a further important problem related to this one of health promotion's descriptive slipperiness. In establishing, and then challenging, a 'moral case' for health promotion, what exactly am I doing? Am I arguing against health promotion being seen as an unproblematic or unambiguous good? The view that health promotion is an unproblematic or unambiguous good is rather a wild one. It is relatively easy to imagine activity that could be thought of as 'health promotion' that contains moral difficulty or ambiguity. Such activity need not be bizarre or outlandish. Consider, for example the introduction of a smoking policy in a workplace with little or no staff consultation on the matter. Or again, breast screening, poorly conducted and badly explained to the patient.

Given this, challenging a 'moral case' for health promotion founded on the view that it is an unambiguous good is rather pointless. It tells us nothing because we know- or could easily find out- that health promotion is not such a good and argue without trouble against anyone making such an assertion. But there is another, more complex position on the good of health promotion. It is that, generally speaking and everything else being equal, it is worth engaging in health promotion. In other words, health promotion is a *prima facie* good.

This is the kind of view expressed by some practitioners (for example, JESSOP, 1991); and by some theorists (for example, DOWNIE, TANNAHILL AND TANNAHILL, 1996). It is the sort of position- because it seems so reasonable- that troubled me most as I was developing my sense of the moral complexity of health promotion, described in the preface to this thesis.

What else would need to be equal in order for health promotion to be a *prima facie* good? Presumably, such things as a shared belief in the worth or value of the 'health' being promoted: a respect for the autonomy of those with whom we are engaging on health promotion; and a desire for them to play at least as much part as ourselves in

activities undertaken and believed to be health promoting. If these sorts of things were in place, health promotion would be likely to be a *prima facie* good.

These are, in fact, elements of the 'moral case' for health promotion I start off by building. So the claims of the case must be seen in the context of a more complex view of health promotion- as a *prima facie* good. A major point, however, in critically examining the case, is to suggest that there are fundamental reasons to believe that everything else is not equal at that point when the good of health promotion is being determined.

In building the 'moral case', I use the understanding and writing of a number of prominent (mostly UK) health promotion theorists. I take their views on the nature of health promotion, what it involves and why it is of value. Their understanding suggests a picture of health promotion as a *prima facie* good. This is a much more difficult position with which to critically engage; if there is doubt about health promotion as such a good, then concerns about its moral value must run deeper than the capacity we easily have to identify some problematic examples from practice. Using these theorists' understanding also helps me with the difficulties I have in 'describing' health promotion. By listening to their 'voices' (rather than relying on my own), I claim to avoid the accusation of 'bias' in the way health promotion is presented. I am not easily knocking down an artificial construction of my own making. I am arguing against the understanding of careful and influential theorists.

So far I have suggested that my moral enquiry is about whether health promotion (here as understood by prominent theorists) is good or bad, right or wrong. At the moment, I have not introduced any views about what constitutes 'good' or 'right', or 'bad' or 'wrong', action. In Chapter Seven, I consider a number of normative systems of ethics and use them in part as background for a response to the substantial flaws in the ' moral case' identified later in the present chapter. I am deliberately not outlining

particular ways of thinking, in a moral sense, about actions and ideas at this stage. My reason is simple. First of all, I want to allow 'my' theorists themselves to express **their** arguments for health promotion as a moral enterprise. It is quite possible, of course, that they will have been heavily influenced themselves by normative ethical projects. But at the moment it is primarily their voices, rather than those of moral philosophers, in which I am most interested.

## 2. The 'Moral Case' for Health Promotion Summarised

It is possible to imagine someone broadly convinced of the morality of health promotion feeling able to offer a robust summary of the 'moral case' for the field. What follows initially is my own construction. It will become clear though, as the case is drawn and examined in detail after this summary, that I have not simply spun, or- re-used, rhetoric. The summary is crudely representative of detailed ideas developed by prominent theorists. It is as follows:

> Health is a value and consequently valuable. At the very least, therefore, it must be considered as something worth preserving and enhancing. This is the primary goal of health promotion which thus becomes in itself a valuable activity. However, health promotion is not obsessed with health at all costs. In fact, its major goal is to encourage individual and population awareness of health choices, so that people can 'choose' health if they wish. Accompanying this is work for structural changes so that social and other environments become health promoting; as the maxim goes it is then the case that 'Healthier Choices become Easier Choices'. So the values central to health promotion include, for example, a concern to respect and encourage autonomy. Indeed, the task of supporting self empowerment is a practical necessity for health promotion: if individuals are empowered, they are more likely to make 'healthy choices'; if they are not, the

effectiveness of the whole enterprise of health promotion is put into question. Finally, health promotion recognises the potential for conflict between the public health and private good and works to resolve this conflict. The methods of health promotion- empowering people as active participants in their own health improvement- themselves ensure that there is alignment between the public health and private good. If health promotion is properly applied, what is not for the private good will not be for the public health.

### 3. The 'Moral Case' : Detail and Objection

The 'moral case' outlined above has three essential and closely connected components. The detail of each needs to be described and assessed:

i. Health is a value;

ii. The goal of health promotion is 'more health';

iii. A principal strategy of health promotion- empowerment- increases the likelihood of 'more health' being achieved and underpins the morality of activity.

(Of course, each of these components underlines again the fact that the 'moral case' is founded on the belief that health promotion is a *prima facie*- and not an unambiguous- good. If it is hard to substantiate the claim that health is a value, in one way or another, for example, then health promotion's *prima facie* goodness is lessened.)

## i. Health is a value

Health is clearly an important societal value. Consider the prominent place 'health' has in the consciousness of very many people (DINES AND CRIBB, 1993). Consider also the relatively large resources that are devoted, one way or another, to 'keeping healthy' and to trying to restore health when it is lost. The pursuit of health has been a major concern of successive post war governments (TIMMINS, 1996); it also preoccupies many individuals (BUNTON, NETTLETON AND BURROWS, 1995). We would probably be inclined to regard 'health' as a normative value; it is sought as a norm by and on behalf of individuals, communities and populations.

While we can fairly easily see the value of 'health' as normative, this does not explain why we believe 'health' has value. Dworkin (1995) offers a helpful way of understanding different kinds of values. We value some things because of their usefulness, their capacity to help us get other things we happen to want or need (**instrumental** values). Other things have **subjective** value; they are valued simply because they are wanted, irrespective of any thought of their utility (these might also be called preference or 'liking' values). **Intrinsic** values are also not reducible to notions of utility or purpose, but this is because they are so fundamental that such reduction would appear absurd. For example, there is arguably an intrinsic value to human life- at least in the sense that it is hard to offer a complete account of the value of life that depends simply on assessing its utility or purpose.

What sort of value is 'health'? It is hard to piece together a coherent account on the nature of 'health' as a value. There is some empirical evidence whose interpretation could suggest its nature as subjective (GLASSNER, 1995). Some philosophers have argued for its instrumentality, suggesting it as the 'foundations for achievement' (SEEDHOUSE, 1986); or as that on which human freedom is contingent (CAMPBELL, 1976). This latter account, although not entirely clear, seems to

propose that freedom itself (rather than health) possesses **intrinsic** value. In fact, supposedly clear- sighted philosophers often appear to conflate ideas about the nature of the value of health. For example:

'[Health] is valued for its own sake; and it is a means to almost all ends....' (WIKLER, 1978: 311).

For Wikler, at least here, 'health' appears to have both instrumental and intrinsic value. Perhaps a reasonable conclusion might be that the nature of health as a value is subject to interpretation and is certainly difficult to assess. But for some health promotion theorists, the issue does not seem to be at all problematic. Take the following, a paraphrase of the World Health Organisation's (WHO) Alma Ata Declaration:

'Health is a basic human right.... health is the most important world wide social goal.... people have a right and a duty to achieve health....' (BARIC, 1986: 367).

This sort of language confirms Yeo's (1993) view of the power of the 'discourse of health'. But in the power of this discourse- natural, given our frequent preoccupation with health or its absence- lies the beginning of a difficulty for this component of the 'moral case'. Health promotion theorists make little attempt to discuss the nature of the value. There is a tendency (unwittingly demonstrated above by Baric) to rely on the rhetoric of, for example, WHO and therefore to share the assumption that health always possesses **overriding** value.

Is this assumption reasonable? There are two reasons for believing it not to be so. First, in a general sense, the kind of evidence so far gathered suggests the problematic in trying definitely to identify the nature of the value. It cannot then always be overriding. For example, I might be less inclined to believe in its overriding nature

based on an instrumental interpretation of the nature of the value than on one which viewed it as intrinsic (or at the very least it is likely there would be competing views about the nature of the instrumental value). Second, there are many specific examples resulting from this general belief where we recognise difficulties in perceiving of, and possibly pursuing, health as an overriding value. Imagine a depressed and confused psychiatric patient who is also a heavy smoker and for whom cigarettes are her only comfort. By the standard of damage to physical health, we would have to agree that her smoking is unhealthy. But can we also agree that the project of encouraging her to stop smoking (that is, the pursuit of the value of physical health) must be undertaken at any cost? Suggesting that we employ an alternative conception of health in this case (smoking is actually the healthy behaviour, at least in the sense of the patient's mental health) simply casts epistemological doubt on the moral difficulty. We are arguing for dominance of a value, and it is apparent from this one example alone that this value 'means different things to different people'. Is it the value of physical health or of mental health that should dominate here? (I will discuss additional problems related to the contestedness of health in the next section.)

Downie, Tannahill and Tannahill (1996) make one of the very few explicit contributions on the part of health promotion theorists to the debate about the nature of health **as a value** (as opposed to the nature of health **as a concept**, which is extensively discussed in the literature). Interestingly, they recognise the difficulties that might present if health was always to be seen as the overriding value and so they allow the possibility of it being in competition with other values. But they, too, cannot resist an attempt to assert their position on values and their relative priorities. They spend a substantial time (DOWNIE, TANNAHILL AND TANNAHILL, 1996: 158-161) trying to identify what they call 'necessary social values' which, they believe, must be widely shared if society is to survive and flourish. Although these values themselves are never made explicit, they are underpinned by general moral principles- for example, avoiding harm to others and attempting to act so that the best possible

consequences are produced for the majority. Downie, Tannahill and Tannahill argue that these principles and adherence to them are intimately connected to societal well-being. For the writers, well- being (positive health) is the goal of health promotion (DOWNIE, TANNAHILL AND TANNAHILL, 1996: 20).

What they have done is to claim necessary (that is to say, special) status for a set of values they consider contribute to well- being (health). Their argument is clever because they have argued for a range of values rather than simply one. They have thus avoided accusations of 'forcing' a dominant value- 'health'- plainly difficult in the face of clear belief that this value and its nature can be disputed. However, the tactical advantage is short- lived. In asserting the dominance of multiple values, they are still vulnerable to the criticism, why **these** values? Why do these values in particular contribute to well- being (health)? Why should we construct, and regard as fundamentally important, a set of 'contributing to well- being' values? The implication remains that well- being (health) actually does have special status as a value and it may be possible to consider that it overrides other values. Downie, Tannahill and Tannahill are clearly attached to this idea although they recognise the difficulties in admitting it.

In the 'moral case' for health promotion rehearsed above, 'health is a value and consequently valuable'. Further, 'health promotion is not obsessed with health at all costs'. Yet identifying the nature of the value is problematic and those involved in theorising on health promotion have not made significant attempts to do so. There is an inclination to view the value as overriding, even when the problems this idea contains have been explored. The first component of the 'moral case' for health promotion appears, therefore, to be suffering difficulties.

**ii. The goal of health promotion is 'more health'**

While we may worry about the kind of rhetoric that bestows on health an overriding value, it would be strange to deny that health possessed no value at all. Health is clearly an important value. Assume for a moment that 'health promotion' is conceived of in the way that it is by the theorists who have 'talked up' and defended the value of health: Baric (1986); and Downie, Tannahill and Tannahill (1996). For Baric, in this particular paper:

'Health promotion is a movement aimed at the achievement of HFA 2000 [Health for All by the Year 2000].... (BARIC, 1986: 372).

Downie, Tannahill and Tannahill view health promotion as a broad set of activities encompassing health education activities: health protection activities; and illness prevention activities; all with the aim of improving health (DOWNIE, TANNAHILL AND TANNAHILL, 1996: 59). Whether a movement or a set of activities, these writers conceive of 'health promotion' as contributing to a state of affairs where more of the value of health exists. For them, the value of health is fundamentally important; thus health promotion (aimed at achieving 'more health') has instrumental value. It does not matter, then, if we do not believe that 'health' possesses overriding value. All we have to consider is that 'health' is an important value for 'health promotion' to have an instrumental value.

This view depends, however, on more or less complete certainty that the goal of 'health promotion' is in fact the achievement of 'more health'. It seems perverse to try and deny this. Yet if we return to theorists' understanding of what 'health promotion' actually is, it is possible to identify the potential for ambiguity within the supposedly clear- headed goal. Downie, Tannahill and Tannahill propose that a range of protective, educational and preventive activities constitute 'health promotion'. Baric

sees it as a movement for Health for All's achievement. The writers reviewed in Chapter One broadly conceptualise it as involving activities based on a medical model (for example, didactic advice giving): on an educational model (such as teaching and learning promoting informed health choices); on a participant- centred or empowerment model (where individuals or communities, rather than professionals, take the lead in identifying health 'needs' and plan to meet these); and on a social change model (in which legal, policy or fiscal change, for example, alters social structures for the benefit of health) (BEATTIE, 1984, 1991: EWLES AND SIMNETT, 1992; NAIDOO AND WILLS, 1994; TONES, 1983, 1986a, 1986b, 1990; TONES, TILFORD AND ROBINSON, 1990; TONES AND TILFORD, 1994).

As I have already argued, models can be interpreted as expressions of values. In particular, they express the value of health although as I have made clear, discussion on the nature of that value (intrinsic or instrumental, for example) is seldom explicit. Underlying expressions of the value through the different models are separate conceptions of the nature of health itself. For example, the medical model sees it as absence of disease; while the empowerment model views it as the capacity to make empowered choices. Returning to the supposedly clear- sighted goal of health promotion- 'more health'- it now becomes reasonable to ask, 'What might "more health" be? Less disease? Greater numbers of properly empowered people?' The goal could be less clear- sighted than we thought.

Extensive theoretical work has been undertaken with the aim of exploring health's conceptual contestability (see, for example, HARE, 1986: SCADDING, 1988; SEEDHOUSE, 1986). Further, there is a literature based on empirical work aiming to assess 'lay' views on the nature of health and its determinants (such as BLACKBURN, 1991: CALNAN, 1987: CORNWELL, 1984: HERZLICH, 1973). Analysis of this work suggests the complexity of both theory and belief about health. However, it seems to be the case that we understand health in broadly two different

(but frequently interplaying) ways: in the negative sense of the absence of illness or disease; and in the positive one of wellness, well- being or even flourishing. Although they hardly do justice to the complexities, health promotion models (as described by the theorists above) can be interpreted as owing greater or lesser allegiance to one or other of these understandings. Moreover, examples of activities that could relate to the individual models could be sharply defined in terms of their understanding of health. For example, childhood immunisation (a 'medical model' activity mentioned in Chapter One) might be based on the belief that health is the absence of disease (that is to say, infectious diseases of childhood). Equally, the 'safe play area' developed by the empowered community in Chapter One (an activity connected to the 'participant-centred/ empowerment model') could be rooted in the belief that health is a more positive concept.

This dichotomy of understanding over the nature of the concept of health spreads still further. There is evidence of at least some theorists being attached to the concept of positive health (BAELZ, 1979: SEEDHOUSE, 1986; WILSON, 1975). But the overwhelming sense from looking at contemporary or near- contemporary guidance and policy on health promotion is of an attachment to health in the negative sense of disease absence (HEALTH EDUCATION AUTHORITY, 1993b: PRIEST AND SPELLER, 1991; SECRETARY OF STATE FOR HEALTH, 1992; SECRETARY OF STATE FOR HEALTH, 1998). Given this, it is even more important to doubt the clear- sightedness of health promotion's goal of 'more health'. 'Health' in what sense?

Why should this doubt about clarity of goal be important? Surely so long as the goal is 'health', it doesn't matter whether this is illness absence or positive well- being or a mixture of the two. Health is being promoted. If 'health' itself is a value (which it seems necessary to agree), then 'health promotion' has at least instrumental value. But the conceptual confusion surrounding 'health' has at least two important effects on the 'moral case' for health promotion.

First and most simply. If the nature of the concept of health is disputed, it is likely there will also be dispute, at least in some cases, about the value of the particular 'good' produced by health promotion activity. At best, value may be seen as insignificant or marginal; at worst, it could be that no value at all is perceived. For example, the adherent to the participant- centred/ empowerment model may see little value in increased levels of childhood immunisation where this has been achieved without the full involvement of the community concerned. An uncomplicated view of the instrumental value of health promotion will thus become hard to take. In a particular situation, some people will perceive health promotion activity as possessing instrumental value; others, viewing exactly the same activity, will imagine it has little or no value in an instrumental sense.

Hare (1986) suggests a way out of this kind of problem. We should allow, even encourage, separate evaluative perceptions of 'health'. For health promotion, the implication is that we should also encourage general agreement on the value of health promotion activity across its range: from that based on the medical model; to that premised on the participant- centred/ empowerment model.

This 'softly softly' response might initially appear a happy solution to the difficulty. However, there are two reasons to doubt its likely success. First, there is little evidence of those involved in health promotion being prepared to adopt this 'reasonable' approach to the nature of the 'more health' being sought. The disputes that characterised my history- telling in Chapter Two and Chapter Three were frequently about- or were underpinned by- disagreement on the nature and causes of health and illness (and consequently on what needed to be done to create 'more health'). Recent policy times have in particular witnessed profound division on the measures required for 'more health' (TOWNSEND, DAVIDSON AND WHITEHEAD, 1988)- a division

not removed by recent UK changes in political control (HEALTH SERVICE JOURNAL, 1999a).

Dougherty (1993) conceptualises this division by offering two opposing models of the relationship between individual behaviour and health status: the Freedom Model (within which a person has free choice and thus responsibility for her or his health); and the Facticity Model (in this, behaviour is a result of genetic and environmental facts and so lies beyond an individual's control). The product of this division is a world divided into 'victim blamers' (subscribers to the Freedom Model) and those with 'bad faith' (in the ability of people to play at least some part in shaping their health, subscribers to the Facticity Model). Dougherty asserts that:

'Understood as a problem of metaphysics, as the freedom versus determinism debate, there is little hope for resolution of the conflict between the Freedom Model and the Facticity Model....' (DOUGHERTY, 1993: 116).

Dougherty's conceptualisation is a further buttress against the idea that those involved in health promotion can accept and work with separate evaluative perceptions of 'health'. 'Bad faith' versus 'victim blaming' is added to 'absence of disease' versus 'well being' and the tangled conflict between separate models of health promotion. The net effect is to reinforce the sense of dichotomy of understanding and belief over 'more health' as the goal of health promotion.

The second effect of the conceptual and practical confusion that exists over 'health' is even more worrying in terms of assessing the nature of the goal of health promotion. Reference was made earlier to empirical work that had identified the complexity of private 'lay' beliefs about the nature of health. Take an example from this work:

'It doesn't matter what you do, you could go out and jog every day and have a heart attack for no reason. You know? I mean, you've got to live life the way you want to and the way you feel you can push yourself.... The way I look at it, if you're going to die of cancer or anything else, you're still going to die of something. You can't be a health fanatic all your life, can you....?' (CORNWELL, 1984: 165-7).

It is worth reflecting on the rich ambiguity of this and similar statements. There seems to be little match between it and the clear- sighted goal of 'more health' identified in the 'moral case'. There is certainly the potential for conflict between 'lay' and 'professional' conceptions of health. Health promotion activities are more often than not planned and delivered by 'professionals' (health promoters and health promotion specialists). So there is also at least the potential for this group to be acting for a version of 'health' of little or no interest or value to those they are supposed to be serving (GRACE, 1991). Unwittingly or otherwise, health professionals may be supporting the maintenance of a set of health- related values that have little to do with the values held by the individuals or communities for whom they work (WILSON, 1986).

It has so far been assumed that the goal of health promotion is, in fact, 'more health'. Objection to this component of the 'moral case' has centred around the conceptual ambiguity of 'health' itself: in particular; what exactly does 'more health' mean?; and is the value of 'health' the same for health professionals as it is for their clients? As if these objections weren't sufficient, there is a further possibility which must be explored- that the goal of health promotion is something completely different to 'more health'.

What is meant by this? How can 'health promotion' be about anything other than 'health', albeit that this concept is highly contested? In Chapter Two and Chapter Three, the history of health promotion was discussed in relation to a number of

dimensions, including the wider social and political context in which its activities have taken place. Health promotion activity itself is undeniably political in the sense that it is concerned with the authoritative allocation of values within a society (EASTON, 1953). Arguably the primary value of concern to health promotion is the value of 'health'. However, the (necessary) intertwining of health promotion policy and activity with other kinds of political policy and activity offers at least the chance that the clear pursuit of this value may be difficult. Indeed, 'health promotion' policy and activity may actually be implemented for non- health ends. If this is so, then we need to examine what goods, or values, are being pursued in order to determine their morality and that of the activity concerned.

Against this point, two things could be suggested. First, supporting 'evidence' would be hard to come by and anything that was available would be subject to interpretation; that is, any activity could be re- interpreted- for ideological reasons- as being primarily undertaken for non- health ends. Moving a little from health promotion specifically to the broader health care arena, take the example from Chapter Two of Will Hutton's (1995) commentary on the conversion of the NHS into a quasi- or internal market. Hutton's argument- part of a much broader analysis of UK society's direction in the early 1990s- was that the changes were inspired by economic considerations and the ideology of libertarianism rather than any desire to improve the Health Service for its own sake. But Hutton's analysis is itself ideological; 'events' could be re- interpreted in a completely different way. Second, and closely linked to the first point, isn't it the case that governments frequently have multiple objectives? Continuing the example of the marketisation of the NHS, economic motivations were also likely to have been connected to considerations more directly to do with health and health care. Wikler (1978), as part of an exploration of possible limits to 'health behaviour reform' (health promotion) identifies two possible goals of such reform, apart from health as a goal in itself. These are the goal of fair distribution of burdens (reducing the burden of illness so that I do not have to pay- unfairly- for someone

else's imprudent health behaviour); and the goal of public welfare (health promotion reduces levels of ill health so that economic function or state defence, say, are improved). Wikler's identification of the possible nature of 'other goals' might suggest that, say, the multiple goals of health, fair distribution of burdens and public welfare objectives are not necessarily incompatible.

I would agree, but at this point it is necessary to return and consider exactly what is being claimed for the 'moral case'. The claim is that 'health' is a value; and because 'health promotion' has as its goal 'more health' it also has (at least instrumental) value. The contingency of the value of 'health promotion' on the value of 'health' is clear. If health promotion activities can have multiple goals then the relationship of contingency is destroyed. It is no longer possible to suggest that health promotion is valuable in a *prima facie* sense because it is about the pursuit of health. The value of health promotion can only be determined on a much stricter, possibly only case- by-case, basis. The requirement for this might be supported by an example. A government might invest in health promotion activity because it believes that the savings from reduced ill health will be substantial. At the moment, goals for this policy might relate to health, but also to fair distribution of burdens (savings devoted to lowering national insurance contributions, particularly for the prudent, say); and/ or to public welfare (assume that savings are devoted to improving education). What if, however, the major goal in reducing expenditure on illness treatment was in order to increase investment in weapons of mass destruction? My assertion is that it is possible to have non- health goals for health promotion which have greater or lesser moral acceptability- and even goals that are unacceptable. Given this, it is over- simplistic to argue the 'moral case' for health promotion on the grounds that the goal is 'more health'. Even if this were only and always the goal, conceptual confusion requires debate about what exactly the value is and whether in particular instances its pursuit (and the nature of that pursuit) is appropriate.

### iii. A principal strategy of health promotion- empowerment- increases the likelihood of 'more health' being achieved and underpins the morality of activity

At this point, the 'moral case' appears somewhat under siege. 'Health' certainly is a value but its nature is open to dispute; and the claim that the goal of health promotion is the value of 'more health' is far from clear. Yet the third component of the 'case' may still be proven. Recall again this part of the outline of the 'case' from above:

'The values central to health promotion include, for example, a concern to respect and encourage autonomy. Indeed the task of supporting self- empowerment is a practical necessity for health promotion: if individuals are empowered, they are more likely to make "healthy choices"; if they are not, the effectiveness of the whole enterprise of health promotion is put into question....'.

The importance of self- empowerment as a strategy to increase the morality of health promotion cannot be underestimated. It will be clear that in itself this part of the 'case' for the morality of health promotion has two connected components. One is that empowerment is a moral value of central importance to health promotion (what I will call the value- in- itself argument). The other is that those involved in health promotion activities must of necessity attempt to empower because empowered people (or communities) are more likely to adopt health enhancing behaviours. Those planning and implementing activities must 'buy into' empowerment if they desire effectiveness and success in what they are doing (what I will call the effectiveness argument). I will describe each of these components in turn. At this stage it is worth noting, however, that if this part of the 'moral case' is to hold water, what must be demonstrated is that empowerment is not only a value of central importance to health promotion; but also that it is a value without moral ambiguity or difficulty in the context of this field of activity. If this cannot be shown, then both components of this part of the 'case' fall into disarray: the value of empowerment becomes disputed (in

the same way that it has been shown to be so with other values connected to health promotion, notably the value of 'health'); and the idea of the requirement to empower in order to be effective becomes a red herring. ('Effectiveness' in itself cannot be a **moral** value, although it may be connected to such values- for example, the value of health. This point is demonstrated when thinking about why those involved in health promotion might want to be 'effective'. Of course, a reason for desiring 'effectiveness' might be to achieve more of the moral value of 'health'- although from the lengthy discussions above it should be clear there is a need to recognise the ambiguities and difficulties inherent within the pursuit of this value. However, there are lots of other non- moral reasons for wanting health promotion activities to be 'effective'- for example, the desire to secure promotion, prestige or more performance related pay.)

The central importance of the value of empowerment to health promotion is fairly easy to identify. There is, after all, a participant- centred or empowerment **model** of health promotion (it is necessary to remember my assertion, from Chapter One, that models function as expressions of ideology or value and not simply or most importantly as descriptive of activity). A variant of one sort or another of this model appears in the taxonomies constructed by all the theorists cited above. In a succession of articles, one especially prominent UK theorist has argued the case for the centrality of self- empowerment to health promotion (TONES, 1983, 1986a, 1986b, 1992). This case has frequently been expressed in terms of the effectiveness argument (although important connections have been made with the value- in- itself argument). I will return to it later.

One of the most articulate expressions of the value- in- itself argument has been that of Michael Yeo (1993). (It is important to note that this argument is seldom explicitly expressed by health promotion theorists. The impression most frequently gained is that empowerment as a value appropriate for, and important to, health promotion is taken as read.) Yeo begins his argument by asserting the two kinds of characteristic

(and opposing) approaches to health promotion ('approach' is used here as a noun, the means of approaching activities or interventions designed to promote health). The first kind of approach is that based on the **individual**; and the second is that based on **systems** (environments). Interventions yielded by the individual approach centre around encouragement of individuals **voluntarily** to change or adapt their health behaviour; while those prompted by the systems approach tend to rely on measures that may be **non- voluntary** (even coercive, at least in the sense of not getting individual agreement for the changes being promoted):

'Viewed in these terms, it becomes apparent that the difference between the two is an ethical difference, and that the individual- versus- the system debate is essentially a moral debate. Indeed, one hears in the health promotion debates today the echoes of an ancient and persistent quarrel between two different ethics: an individualistic or libertarian ethic and a collectivist or communitarian ethic....' (YEO, 1993: 228).

For Yeo, this 'ancient and persistent quarrel' is tiring and dispiriting. His conceptualisation can be traced against that of Dougherty (1993). The individual approach aligns somewhat with Dougherty's Freedom Model; and the systems approach with that of the Facticity Model. For Yeo, like Dougherty, the problem lies in failure adequately to understand the relationship between freedom and health choices. The advocate of the individual approach possesses an over- optimistic view of our capacity with regard to free will. This in turn leads to a 'it's down to you' style of health promotion activity and consequent 'victim blaming' when things fail to work out. The supporter of the systems approach, on the other hand, denudes the individual of freedom and opens the door to 'non- voluntary' or even coercive health promotion. Both approaches are inadequate as ethics for health promotion.

Yeo's solution to his conceptualisation of the health promotion dichotomy is to assert the centrality of empowerment as an approach to, and ethic for, the field of activity.

There is a need to recognise (as the systems supporter does) that community is a value and a key task of health promotion is to build community. Equally, individual freedom and responsibility are values. The appropriate way to see the relationship between individual and community is as mutually supportive and reinforcing, and the way to encourage this relationship to develop is through empowerment, the appropriate attribution of prospective responsibility:

'Attributing responsibility in a prospective and empowering sense encompasses a wide range of empowerments from moral exhortations and inspirational messages to giving (or even relinquishing) responsibility. To attribute freedom and responsibility in the sense of giving people control over solutions to problems may involve giving powers and resources in order for them to do so. Attributions that do indeed empower people to assume greater control in matters of health are a vital part of the health promotion philosophy I am sketching here and are to be prized in so far as they serve to promote not only health, but also freedom and community....' (YEO, 1993: 232).

Yeo's effort to draw together competing approaches to health promotion by positing an 'ethic of empowerment' bears very close resemblance to Dougherty's conclusions. From his Freedom and Facticity Models of health, Dougherty argues that while a health promotion policy framework should 'maintain public sympathy for those in need' (DOUGHERTY, 1993: 118); importantly it should emphasise peoples' capacities to choose health improving behaviours:

'Not only does this seem to be the honest truth, it is also *empowering*. Compared with the alternatives of avoiding individual health education or freighting it with qualifiers about the social context, this approach makes direct appeal to the dignity of each individual. It addresses people as persons with some say over their destinies. It denies that people are merely passive vehicles for their own habits and offers a degree of control and therefore self- esteem....' (DOUGHERTY, 1993: 118, italics added).

At this point, there is not a great deal of distance between the value- in- itself and effectiveness arguments. In different ways, both Yeo and Dougherty relate empowerment to allowing the assumption of control, necessary because of our belief in the values of individual freedom and of community. Because these values are fundamental, any attempt to limit or deny them is to deny human aspirations and therefore ultimately likely to be self- defeating. 'Blaming' and 'removing control' are unlikely to change health behaviour; supporting and enabling individual freedom is. Tones writes:

'It would be generally accepted that empowerment involves (i) having a range of competences which provide individuals with experience of controlling their lives and their environmental circumstances and (ii) having a conviction that you are in fact mostly in charge of your life. Beliefs about control are often described in such terms as "self efficacy beliefs" and "perceived locus of control". The former is represented by a belief that a particular course of action is not only worth undertaking (e.g. stopping smoking) but that you can **actually do it!** Those individuals who have accumulated a large number of specific self efficacy beliefs will develop a generalised expectation of effectiveness. In other words they will have an "internal" locus of control. Those who have experienced failure, on the other hand, are likely to be governed by "externality", i.e. to believe that any good or bad fortune which they experience will be due, either to "powerful others" or "chance"- or both....' (TONES, 1992: 135).

It becomes clear that the more belief I have in my own self- efficacy, the more likely it is that I will positively control my own behaviour for my own ends. This does not, of course, necessarily mean that my behaviour will always be 'healthful' (whatever might be understood by this). However, there is much more chance of it being so than if I was 'controlled' because in the latter case I would be the helpless subject of a

range of forces, many of which are likely to be 'against health'. Further, there is a sense in which empowerment is itself 'health'. Tones writes thus about health education (which he sees as the fundamental building block for health promotion):

'It seems clear that child- rearing which provides a high level of nurturance together with an emphasis on independence will facilitate autonomy and genuine informed decision- making.... Similarly, primary socialisation which is future- oriented and emphasises the value of deferred gratification will facilitate acceptance of behaviours which have long- term benefits at the expense of immediate pleasure or relief from stress. For all of these reasons health education must seek to provide self empowerment both for individuals and communities....' (TONES, 1983: 124).

Self- empowerment based health education (and health promotion), then, represents the value of individual freedom. It increases the likelihood of 'more health' being achieved; and means that health education and health promotion enacted in this way will be moral. Moreover, empowerment extends beyond work with individuals to work with communities:

'Another key aspect of importance to health promotion.... [is] community participation. Community participation is facilitated by the possession of appropriate lifeskills together with beliefs about efficacy and control. Community participation is also a context in which life skills may be acquired and self efficacy beliefs acquired. It also seems likely that community participation is a major source of self esteem....' (TONES, 1992: 135).

The relationship between individual self- empowerment and community empowerment is essential and reciprocal. Effective health promotion depends on both empowered individuals and empowered communities because they are sources of

strength and learning for each other. The moral value of empowerment health promotion to both individuals and communities is clear.

Here, it might seem that we have turned the tide back in favour of the 'moral case'. It does not matter, we could argue, that 'health' is a disputed value and that there is equal dispute about the goal of health promotion being 'more health'. Health promotion's principle strategy of empowerment increases the likelihood of it being effective; but it also underpins the moral value of activity. Freedom and community are fundamental values; empowerment supports both.

It must be admitted that the 'case' at this point does appear strong. It is not particularly weakened by any claim that health promotion activities are at least sometimes not based on strategies of empowerment. It could be argued in return that these activities may well present moral difficulties but that 'authentic', empowerment- based health promotion does not. (Remember that I am building and challenging a case for health promotion as a *prima facie*, rather than an unambiguous, good.)

This would be a perfectly reasonable position, except it is allowing the advocate of empowerment health promotion to claim a moral high ground to which they are not entitled. The assumption made by a writer such as Yeo, and others asserting the 'value- in- itself' argument, is that empowerment is an **uncomplicated** moral value. It is necessary to remember that in order for this component of the 'moral case' to retain its strength, it must be shown not only that empowerment is a value of central importance to health promotion; but also that it is a value without moral difficulty in the context of the field of activity.

Fielding (1996) argues it is possible to construct two key accounts of empowerment. The first (and dominant) is the 'process' or 'neutral' account. This account centres on the idea that those who have power decide appropriate others should have greater

power and so 'transfer' or 'give' this power to these others. Although not explicit, it seems to be in part this kind of account of empowerment that Tones (1992) is constructing. When he talks (from above) of 'having a range of competences....' and of 'having a conviction....'; the implication is that somewhere along the line, these competences and convictions have at least in part been developed by allowing the 'competent' person access to education and so forth.

The second account is the emancipatory account. Here it is argued that empowerment cannot be characterised simply as a 'give and take' process. Transfers of power are often problematic and value- laden:

'Empowerment.... is a struggle in difficult and often hostile contexts.... The point of the struggle is to realise a view of social justice and the development of the democratic way of life....' (FIELDING, 1996: 405).

It is hard to be clear about which account of empowerment is accepted by those involved in health promotion. I have suggested that Tones implies a view of empowerment as process. Yet there is also an emancipatory ring to the following:

'[An empowered participating community] may offer a fundamental challenge to government, the status quo and the existing power base. It is based on the notion that only community action and the ballot box offers a prospect for such radical change as is involved, for instance, in dealing with problems of unemployment, poverty and general inequity. The.... process is essentially one of "critical consciousness raising" (to employ Friere's seminal term) accompanied by the provision of empowering social and general life skills....' (TONES, 1992: 135).

Let us assume for a moment that those involved in health promotion activity are inclined towards a process view of empowerment. Power is 'transferred' between

different parties. But this notion holds a number of inherent difficulties. First, the idea of 'power' being parcelled up and changing hands is both ontologically and epistemologically problematic, especially if we accept Foucauldian notions of power as constantly shifting and circulating rather than as a commodity 'held' by individuals or groups. Second, and more importantly given our concern with health promotion, empowerment as process implies particular kinds of relationships; powerful individuals or organisations bestow through largesse some of their power on those who previously had none, or at any rate, less. This kind of relationship does not sound 'empowering' at all. Conceiving of empowerment in these terms will pose special difficulty for those involved in health promotion activity, given that health promotion can be regarded as:

'The process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health....' (NUTBEAM, 1986: 114).

The difficulty is that if the powerful bestow power on the powerless, control is always in the hands of the former group. If empowerment is indeed process, who decides on 'balances of power' and on what grounds are such decisions made? If those involved in health promotion activity see power as a transferable commodity, then they must enter debates about when and why transfer of power from individuals or groups to others should begin and end. These debates will involve conflicting values (for example, the value of 'social stability', as it might be seen through the eyes of the powerful, against the value of 'social justice', and the need to increase this, as it might be perceived by those with less power or those working on their behalf). Even on a process account, empowerment starts to take on the appearance of a problematic value.

If it is assumed that those involved in health promotion activity understand empowerment as emancipation, the possibility of debate does not disappear- it

simply becomes more explicit. According to Fielding, the emancipatory account views empowerment as 'a struggle.... to realise a view of social justice'. This might appear attractive to those involved in health promotion activity but again it renders the value of empowerment problematic. Views of what constitutes 'social justice' are bound to differ: struggles are unlikely to be divorced from values conflicts.

A more detailed account of empowerment, therefore, exposes its problematic nature as a value. Transfers of power between individuals, groups, communities and populations are highly unlikely never to be disputed. And as soon as the potential for dispute emerges, the 'value- in- itself' argument for empowerment underpinning the morality of health promotion is substantially weakened. This, as I have made clear, is all that needs to be demonstrated to shake the view that empowerment guarantees the morality of health promotion as idea or field of activity.

## 4. Conclusion

I have put forward a 'moral case' for health promotion as a *prima facie* good with three key components: health is a value; the goal of health promotion is 'more health'; and a principle strategy of health promotion- empowerment- increases the likelihood of 'more health' being achieved and underpins the morality of activity. But each of these components can be challenged. The nature of health as a value can be disputed. The goal of health promotion as 'more health' can be challenged (both in terms of potential argument about the nature of the 'health' being sought and in terms of whether activities and interventions are actually about 'more health' at all). Empowerment (contrary to its presentation by theorists) can also be seen as an ambiguous and problematic value.

The difficulty is this. While it might superficially appear reasonable to claim the *prima facie* good of health promotion; there is substantial evidence to believe that in key areas supporting the qualification of that good, major problems exist. Health promotion cannot automatically be seen even as a *prima facie* good because there is little sense that other things relating to that notional good (such as the values of health and empowerment) are ever likely to be equal. They contain far too much complexity.

I began this project convinced that health promotion as concept and set of activities held substantial ethical difficulties. I was impelled to this view by my own perceptions and experiences. Analysis of the history of the field of activity demonstrated substantial conceptual, political and practical dispute. Reflection on this supported my view that here was an area ripe for moral probing. I then began to listen to the voices of theorists to understand (albeit often through interpretation) how a 'moral case' for health promotion might be made as a way of responding to my initial concerns. Yet the theorists' voices have so far failed to convince me.

Are my worries shared by others? Do my doubts about the morality of activity and the ambiguity of key concepts underpinning it find expression elsewhere? In order to address these questions, I need now to listen to another set of voices- those of some who are involved in the practice of health promotion work.

# CHAPTER FIVE- THE MORAL PROBLEMS OF HEALTH PROMOTION: PRACTITIONER PERCEPTIONS; (1) CONTEXT AND METHODOLOGY

## 1. Introduction

In this chapter, I describe and discuss the context in which I heard practitioner 'voices' on the moral problems of health promotion, and the methodology I employed to do so.

I took and analysed writing produced for assessment by two cohorts of health promotion Masters level students, the great majority of whom were also practitioners in the field of activity. The writing related to a taught module on 'Philosophy and Health Promotion' held at South Bank University, London during academic years 1995-6 and 1996-7. Textual analysis is a methodology applied reasonable commonly in academic consideration of health care and the field of health promotion (particularly at policy level). Examples of such application include Schuklenk, Mertz and Richters (1995): Wilton (1995); and Lupton (1998). To my knowledge, however, the technique of analysing **student writing** to illuminate practices within, and theoretical roots to, the field is novel. I begin this chapter with a description of the research context; together with my own, and my participants', places within it.

## 2. The Context of the Research

As already indicated, I analysed a number of assignments produced for assessment by two cohorts of students undertaking Masters level postgraduate studies in health promotion at South Bank University, London. The students had been required to write:

'A critical report reflecting on the philosophical basis of an ongoing programme in a health promotion establishment.... ' (SOUTH BANK UNIVERSITY, 1995b: 16; 1996b: 17).

The assignment related to the philosophy and health promotion (PHP) unit of the South Bank postgraduate programme in health promotion. The complete brief for the assignment appears as Appendix One. (From here on, the terms 'report' and 'assignment' are used completely interchangeably.)

Overall, the postgraduate programme aims to encourage the development of knowledge about, and critical awareness of, theory and practice related to the 'dynamic field' of health promotion (SOUTH BANK UNIVERSITY, 1995a: 4; 1996a: 4). Specifically, learning outcomes for the PHP unit include the student being able to:

' Identify philosophical and ethical issues in our own health promotion practice....' (SOUTH BANK UNIVERSITY, 1995b: 1; 1996b; 1).

I analysed the writing of some of the cohorts of students who studied the unit during academic years 1995-6 and 1996-7. The unit syllabus for these years appears as Appendix Two.

It is not necessary to say very much about the syllabus other than to note that, although the unit title is **philosophy** and health promotion, its emphasis is clearly on ethics, and on moral philosophy. There is much less explicit concentration on other aspects of philosophy arguably of great relevance to the field of health promotion; for example, epistemology and political philosophy. This focus is largely explained by the teaching interests and expertise of the staff involved.

Seventeen students registered for the PHP unit during academic year 1995 - 6. I asked permission from all of them to analyse their assignments through a letter with a 'tear-off' reply slip (appearing as Appendix Three). Four did not reply to my request, leaving 13 from whom I did receive permission. Two of those who had given their permission either did not complete the assignment, or their work was mislaid before I was able to see it, meaning that I eventually received 11 completed reports for analysis from this first cohort.

For academic year 1996 -7, 10 students registered for PHP. Seven students agreed to me using their work (I wrote to them and asked them to reply in the same way as before). One of these pieces of writing was mislaid so I had six assignments from this second cohort to analyse and thus 17 in total from across both.

All 17 in my eventual sample were registered for part time study at the University (full time students on the programme are relatively rare). All the students whose work was analysed combined this part time study with at least part time paid work, although the actual time commitment to, and permanence of, this work did vary considerably among the sample. But this work always had at least some kind of health care and/ or health promotion focus. Following the distinction made through this thesis, nine (or just under half of the total sample) were **health promotion specialists**; the rest were **health promoters.**

### 3. 'Voices' of the Research- the 'Cast of Characters'

Here is the 'cast of characters' in the sample that eventually emerged from the two cohorts- the 'voices' that I am now hearing speak about moral problems of the field of health promotion. Names have been changed, and any particularly distinguishing features either altered or removed, to preserve confidentiality and anonymity.

Although described in the present tense, my participants' occupations and other circumstances are those at the time when they were studying on the unit and writing the assignment.

**David** works for the public health directorate of a commissioning NHS health authority in South London. He has particular responsibility for substance misuse contracts. David chose to write his assignment about the moral implications of 'Tackling Drugs Together', the former Conservative Government's national strategy for drug misuse control and prevention (HER MAJESTY'S STATIONERY OFFICE. 1995).

**Liz** is a health promotion specialist working in a NHS health promotion department serving a wide area of rural East Anglia. She decided to write about 'Drinkwise', the national sensible drinking campaign (HEALTH EDUCATION AUTHORITY, 1992).

**Melanie** is also a health promotion specialist who works in a NHS department in one of the home counties. Melanie wrote about ethical difficulties associated with local work on smoking and pregnancy.

**Patricia** works as a freelance health promotion consultant. She has undertaken quite a lot of work for a North London NHS specialist health promotion service. Her assignment was about epistemological and moral difficulties associated with a general practice- based needs assessment she undertook for this service.

**Carol** is a health promotion specialist, working in a NHS department in an English south coast town. She has particular responsibility for outreach work, the ultimate focus of which is HIV and sexual health. She decided to write about ethical problems connected to outreach work with young people.

**Mandy** is another health promotion specialist working in a NHS department to the west of London. Her work includes responsibility for supporting schools health promotion and she chose to write about a self- esteem project developed within a local primary school.

**Sophie** is also a health promotion specialist, working in a NHS department based in an English south coast seaside resort town. She wrote about the ethical problems associated with local implementation of the national breast screening programme (FORREST, 1986).

**Alison** is a lecturer at a further education college in South London where her particular responsibility is for teaching a range of health and social care- related courses. In her assignment she addressed issues associated with the introduction of a no- smoking policy by the college management.

**Iris** is a community dentist employed by a NHS Trust in one of the home counties. She wrote about local decisions and action in relation to fluoridation of the public water supply.

**Moira** is a nurse teacher. She works in a college of nursing linked to a London teaching hospital. She looked at understandings of the concept of 'autonomy' and the principle of 'respect for autonomy' held by some of the students she teaches.

**Donna** works as a health promotion specialist for a local district council in Southern England. She wrote about the link between ethics and politics in health promotion work, based on her experience of involvement in the council which employs her.

**John** is a health promotion specialist, working for a NHS department serving a wide area of rural and coastal East Anglia. He has particular responsibility for work on

smoking prevention and chose in his assignment to write about the introduction of smoking policies in schools.

**Judith** is also a health promotion specialist, employed in a North London NHS health promotion department. She too works on smoking prevention issues and looked, in her writing, at local work training midwives to be effective health promoters on the issue of smoking and pregnancy.

**Tim** is the HIV and sexual health team leader of a NHS specialist health promotion service located in an East Anglia university city. He decided to write about a Christian voluntary group with which he has a lot of professional contact. This group offers help and support to local female sex industry workers.

**Anthony** is a clinical nurse specialist for HIV, employed by a NHS Trust serving a large South Coast seaside resort and its surrounding area. Anthony looked in his writing at moral issues associated with advising HIV positive patients about anti- HIV combination therapy.

**Jennifer** is a midwife practitioner working for a South London NHS Trust. She chose to focus in her assignment on the ethics of the UK National Breast Feeding Initiative (DEPARTMENT OF HEALTH, 1995a).

**Julie** is a health promotion specialist working for a NHS health promotion department in one of the home counties. She has particular responsibility for supporting health promotion work with young people and decided to write about a local peer education project.

To my knowledge, all of the health promotion specialists in the sample were 'second career migrants'; they had come to the specialism from another 'first career'

occupation (RAWSON AND GRIGG, 1988). Occupations from which they had migrated included teaching and nursing.

## 4. Methodology

It is important to note- a point which may be guessed from the above- that all the sample chose to focus on ethics in response to an assignment requirement that could, in theory, have elicited responses connecting health promotion to other branches of philosophy. The fact that it didn't perhaps relates to the nature of the teaching students experienced. As I have already indicated, this leant heavily in favour of the application of ethics, and of moral philosophy, to the field of health promotion. I have also suggested that one of my key concerns at this stage of my thesis is to determine whether the kinds of moral worries I have identified in relation to health promotion are shared by any others- in particular, by practitioners.

It could be argued that asking questions about ethics- even, as I was effectively doing, indirectly- of students on what was essentially an 'ethics and health promotion course' is bound to result in expressions of moral concern. To expect otherwise is rather like building a motorway in the expectation that no traffic will travel on it. I am therefore almost guaranteed supporters in my worries.

I acknowledge this is a methodological tension which will be discussed in more detail later on. However, what I am deliberately not doing here is directly asking any kind of question at all of my participants. I am analysing, remember, writing responding to the set task, to produce a:

'Critical report reflecting on the philosophical basis of an ongoing programme in a health promotion establishment....'.

This is a key reason for my choice of method; not asking questions myself will mean I cannot be accused of seeking allies for my own 'case'. Against this, though, it could be argued that while not asking questions directly, the combination of heavily weighted teaching and an assessment *diktat* mean my sample will be substantially biased in my favour. I do not necessarily agree with this but assuming it to be the case, the expectation would be that at least some of the assignments would be 'artful constructions' of a morally ambiguous fictional world which is not actually reality for the respondents. Indeed, some of the constructions would possibly not be artful at all, but easily seen as fictions. As I will show in the following chapter, my 'voices' are frequently talking in challenging ways about practice being undertaken in response to national, regional or local priority and direction. 'The Health of the Nation', 'Tackling Drugs Together' and so on actually existed at the time my participants were writing (and they have been replaced by similar kinds of policies and priorities). These students/ practitioners are responding with 'real world' reflections to a requirement to 'write philosophically'.

The implication is that in constructing my methodology, I am interested in finding out about not only whether my moral doubt is shared; but also about how ethical ambiguity or difficulty emerges and is demonstrated in practical activity. I readily agree. Indeed, this part of my research represents a switch from critical examination of an abstract theoretical case for the morality of the field; to how such theoretical weakness impacts on practice. Later, I will return to theory- this time explicitly moral philosophical theory- to see whether it can provide 'solutions' to the kinds of problems identified by my participants. Indeed I will come back, towards the end of this thesis, to the 'voices'- my participants- themselves to hear whether they believe moral theory can help. Thus in this research I chart my way around- in a similar fashion to my participants, I argue- a 'reflective cycle' based on the assumption that it is possible to:

'Reveal, describe and interpret the past experience of individuals in order to illuminate the present and make manifest the potentialities of the future....' (JP Powell. quoted in HARRISON, 1992: 5).

My method, then, has been devised to explore three intimately connected questions: are others worried about the morality of the field of health promotion?; how does moral difficulty emerge in practice?; and how is it dealt with? In Chapter Six, I chart my participants' response to the first two questions; and to the third in Chapter Nine. The method- textual analysis of a specific kind- and the methodology have been employed in part because they allow me to 'ask' these value- laden questions from a distance.

There are, of course, other reasons for my methodological choices. I have already mentioned the interesting and helpful tradition of textual analysis in the area of health care and health promotion at policy level. My interest particularly in practitioners' perceptions and experiences means that traditional sources used in textual analysis (in the main, mass media) are unlikely to be of help to me. The apparent worth of such analysis as a method: and the desire not to be seen to be overtly asking questions (other than in a very general sense); prompted me to consider use of student assignments produced on the unit I was involved in teaching at the time. It was also, of course, the case that access to this material and these 'voices' proved to be relatively easy. Further, the 'voices', given their circumstances, were likely to be interested in the issues which were of concern to me. It was hoped they would prove to be not simply a source of data, but a rich and insightful source. I needed to encounter as few difficulties as possible as I moved from the theoretical to the empirical. At this point in my research, the majority of my working life was being spent in an uncertain, unsympathetic and non- academic work environment. It is important, as Williams says, to be honest about personal influences on the researcher and their impact on decisions made:

'There is a strong argument which says that it is important to acknowledge personal experience, in terms of your location in society, as a lens through which you make sense of the world and reshape existing knowledge....' (WILLIAMS, 1993: 12).

I was reshaping for myself in the context of other quite considerable pressures. However, it is also important to be clear about limitations to methodology and method.

First, my sample was obviously one of convenience (COHEN AND MANION, 1989). Its nature as such means that it will be impossible to infer any generalisations from these 'voices'. This did not worry me unduly as I made my decisions. To my knowledge, health promotion **practitioner** views on, and experience of, moral difficulties has been poorly researched, if at all. (Although there is an emerging trend towards 'empirical ethical research' in other areas of health care and with regard to other health care- related occupations or aspects of occupation. See, for example, Carter (1998) and Soafer (1995).) This suggested to me that my work should be oriented towards developing understanding rather than its capacity for generalisation. I was committed, quite reasonably, to methods grounded within the qualitative paradigm (GREENHALGH AND TAYLOR, 1997).

Indeed, it is important to emphasise the limited claims I am making for the data resulting from this part of my research; and presented in the following chapter and in Chapter Nine. These are views and expressions that I have connected to the three questions of fundamental interest to me in the context of my research as a whole: do others share my moral worries?; how does moral difficulty emerge in practice?; and how is it dealt with? They are views from a small number of practitioners with particular backgrounds and interests. However, drawing out limits to claims being made on behalf of the data should not dilute the importance of what was in fact

discovered. Up to this point of my research, I have gathered significant historical and theoretical data that has been interpreted as confirming my initial moral unease. In planning this next stage, I wanted to have another 'point of reference' for what has so far been theoretical work informed by personal experience. My participants provided this, showing that others did share my worries: that there were ways in which difficulties emerged; and, ultimately, that there were routes to dealing with problems.

I undertook my analysis of the reports following assignment submission by the second cohort of students to whose work I had access. Analysis was done during the period between March and October 1997. Prior to this I had developed a clear sense of the general nature of the kind of data I was about to analyse. In particular, I was aware that writing is a fundamentally important way in which students in higher education make sense of the subject they are studying; and in which academic staff assess the development of that understanding (CREME AND LEA, 1997). Further, student writing takes place in distinctive social structures (LEA AND STREET, 1999: LEA AND STREET, UNPUBLISHED). Academic institutions are sites of discourse and power (LEA AND STREET, 1999). It was clear that students would be responding to these demands and the nature of the structure in which they were operating. However, while it was important that I recognise this, it should not overwhelm my analysis. I was taking their writing for the purpose of asking my own questions. As I have already made clear, I was 'asking the questions' implicitly and at one remove. Because I had not been involved at all in the process of assessing the assignments: and because of the nature of my relationship to the course (an hourly paid lecturer with a temporary contract); I was also rather removed from the structural context within which they were writing. My task was to interpret their writing to inform questions relating to my research at this point, albeit acknowledging the nature of the specific context from which the writing had emerged.

I began my analysis by reading through all the reports and making notes on them, in order to get a broad sense of the topics being addressed, the settings within which activity was taking place, main protagonists within each of the stories being told through the writing, and so on. Then I read through each of the reports in more detail and at this stage attempted to 'code' the writing. I employed a process of open coding, breaking down the data, analysing it and then trying to 'reconstruct' it according to putative categories or 'themes' which appeared to emerge as a result of this process of sifting (STRAUSS AND CORBIN, 1990). To begin with, I was dealing with a large number of themes- anything up to 20- which sought to categorise both what students were writing about (content); and how they were writing about it (process). Gradually, as I developed greater and greater familiarity with my participants' 'voices' and the stories they were telling; the categorisation of what was being written about as opposed to how it was being written about became less important. I began to see the stories as complete again and representing a small number of singular themes. (For example, I finally presented the data relating mainly to my first and second questions- are my worries shared and how does moral difficulty emerge in practice?- according to just four themes.) In my final presentation and discussion, I regarded the stories as complete- expressions of rich and complex thoughts on the part of skilled and knowledgeable practitioners.

For purposes of clarity, my presentation of the analysis results and discussion moves in the following chapter from description of the background of the 'stories' through to identification of moral difficulties. In Chapter Nine, I move to consider and discuss ways in which participants dealt with difficulties as part of a broader attempt on my part to construct the grounds of a methodology for dealing with the moral problems of health promotion. I connect these ways of dealing with problems more specifically to the process of reflection the writing seems to me to demonstrate; and suggest that this process might be a helpful way of coming to terms with the ethical difficulties presented by health promotion. However, it should be noted that this separation

between 'difficulties' and 'resolution' is a form of mediation on my part between my participants and the reader of this thesis. Those whose writing I analysed wrote about engaging things in engaging ways; artificially separating what was written about should not in any sense belie the richness and complexity of these 'voices'. In order to maintain that sense of richness as fully as possible, I have quoted from the writing of my participants without altering what they wrote in any way (unless, of course, confidentiality or anonymity needed to be protected). Sometimes I have 'connected' quotations together in order to aid understanding, but the writing itself has not been changed.

## 5. Conclusion

In this chapter, I have identified my purpose in analysing the critical reports produced by two cohorts of students studying on the South Bank University Postgraduate Programme in Health Promotion during academic years 1995-6 and 1996-7. I have described the context of my analysis. I have also described my methodology and discussed some of its inherent limitations. Overall, however, the methodology offers important possibilities for helping me with the central questions of this research.

I now move to present and discuss the results of my analysis in relation to my first two substantive questions: do others share my moral worries about health promotion?; and how does moral difficulty emerge in practice?

# CHAPTER SIX- THE MORAL PROBLEMS OF HEALTH PROMOTION: PRACTITIONER PERCEPTIONS; (2) RESULTS AND DISCUSSION

## 1. Introduction

In this chapter, I present the results of my analysis of student writing in relation to the first two broad issues this part of my research is trying to explore: is the 'moral doubt' I constructed for myself about the field of health promotion shared by others?; and how do moral difficulties emerge in practice?

After describing and discussing the contexts and activities about which my participants were writing, I identify a sense of 'moral unease' among them, connected to difficulties both with those contexts and with those activities. Problems seem to emerge for my participants because of the following closely linked reasons, each of which I explore in some detail:

* Diverse perceptions on the part of different people involved about the nature of health promotion priorities, needs and values;

* Competing views resulting from these diverse perceptions about what constitutes justifiable activity;

* A lack of shared understanding about the nature of concepts believed to be centrally important to the promotion of health;

* A lack of agreement about what constitutes acceptable knowledge of the 'effectiveness' of activity when its potential for harm (or for benefit) was being considered.

Discussing the moral problems of health promotion at this stage of my research begs the same question encountered at a number of earlier points: 'What is health promotion?' As before, I intend to hear the voices of others, rather than my own, responding to it. The voices this time are those of the practitioners whose writing I have analysed. At least superficially, their response seems clear. Remember that they are writing a:

'Critical report reflecting on the philosophical basis of an ongoing programme in a health promotion establishment....' (SOUTH BANK UNIVERSITY, 1995b: 16; 1996b: 17).

It would be reasonable to assume that for the writers, 'health promotion' is a set of activities that includes among other things strategic work for drugs misuse prevention; sensible drinking campaigns; advice for reducing or stopping smoking during pregnancy; and breast screening (because these are some of the subjects my participants chose to write about). However, it will become clear that one of the many tensions within much of the writing is the question of whether the activity being considered (say, breast screening) is 'authentic' health promotion. As I have mentioned, one of the 'problem themes' I uncovered in my analysis was that of competing views about what constitutes justifiable health promotion activity. I will suggest that for some participants at least, what they perceived as unjustifiable activity could hardly be regarded as 'health promotion' at all.

It is also necessary at this point to mention the issue of time. All my participants were writing during the period between the end of 1995 and the beginning of 1997. They

were describing and discussing activities that were being undertaken either directly within this period or shortly before it. The middle years of the 1990s were the era of 'The Health of the Nation' (SECRETARY OF STATE FOR HEALTH, 1992) and the point at which an oligarchy was beginning to realise that the power it had enjoyed since the end of the 1970s- and which it had used to change society in ideologically driven ways- was likely to slip away. The contemporary nature of the writing I analyse will become clear but interestingly it is possible to note that many of the practical issues encountered and described by my participants remain, even after political changes. The 'problem themes', I argue, are enduring.

## 2. The Moral Problems of Health Promotion: Results and Discussion

### 2. 1 Health Promotion Topics: Signs of the (Particular) Times

Of the reports considered, 12 out of 17 explored work on a particular health or disease prevention topic. These were: drug misuse; HIV (prevention or treatment); sexual health; sensible drinking/ alcohol misuse; breast cancer; smoking; infant feeding; and dental health. These topics were linked to what were then current national or local strategic initiatives related to health (SECRETARY OF STATE FOR HEALTH, 1992; DEPARTMENT OF HEALTH, 1993a; HER MAJESTY'S STATIONERY OFFICE, 1995; HERTFORDSHIRE HEALTH AGENCY, 1995; DEPARTMENT OF HEALTH, 1995a, 1995b).

Most of the participants had been expected- through mechanisms like contracts and job descriptions- to work on the topic about which they were writing. For example:

*' It was expected that I work in my capacity as a Health Promotion Adviser to meet the targets set by the Health of the Nation Document. This included.... promoting the breast screening programme....'* (Sophie).

*'As the Public Health Officer responsible for substance misuse contracts, I was asked to put the necessary local arrangements in place* [for implementing the national "Tackling Drugs Together" strategy] *and produce the required reports to central government via the Central Drug Co-ordination Unit....'* (David).

*'From a contractual point of view our programme is intended to meet the Health of the Nation target specifically related to alcohol....'* (Liz).

Even 'mission statements' were cited as imperatives to activity:

*' S.... Community Health Care NHS Trust in its mission statement states that "the main purpose of community health services staff is the promotion of health, the prevention of illness and the provision of treatment, care and services to meet the needs of individuals, their families and carers"....'* (Carol).

Frequently, this organisational or political requirement for action appeared to be independent of any thought about whether there was actually local **need** for the topic to be addressed:

*'Why Tackling Drugs Together, why the priorities and why now....?'* (David).

I interpret David's questions as rhetorical. He made it clear that he was asking them knowing the answer would be that his organisation was obliged to become involved in implementing the strategy. There was no invitation to participate- it was a requirement.

If there had been discussion about the relative priority of the topic concerned, it was usually in relation to organisational capacity and expectation, rather than local health need:

*' It should be noted that this area* [sensible drinking] *has been given low priority in the wake of staff shortages....'* (Liz).

*' In E.... Health Authority's Cancer Prevention Strategy.... targets were set for the number of midwives trained* [in giving smoking cessation advice]....' (Judith).

However, four of the reports did suggest that a version of 'need' was being considered in relation to the activity being discussed. Their reference is largely to normative conceptions of need (SEEDHOUSE, 1994):

*'Incontrovertibly, water fluoridation is* ***usually*** *the most cost effective way of preventing decay. It reaches all members of the population and has life long benefits.....'* (Iris).

*'Last year in N....E....* [district], *ten secondary schools competed the* [Exeter University Schools Health Education Unit] *Health Related Behaviour Questionnaire. One school's individual results showed at year 10 almost 50% of pupils were regular smokers....'* (John).

*' I have chosen to examine an outreach project in L...., a small town on the edge of D... Marsh. With a large population of young people, L.... was seen to be an area of need due to lack of easily accessible health services, few recreational facilities and a higher than average teenage pregnancy rate....'* (Carol).

*'Although* [work with local sex industry workers has been] *identified as* [emerging from] *a normative need, the approach has been, from the outset, client- centred....'* (Tim).

## 2.2 The Reports and Health Promotion Activities

All 17 assignments described and discussed a particular activity or set of activities that were being undertaken either in a generic sense or in relation to a specific health or disease prevention topic. These were:

* Health policy and strategy implementation and development;

* Environmental regulation;

* Campaigns;

* Screening;

* Advice- giving/ counselling;

* Outreach work;

* Training (to enable other health professionals to become more effective health promoters);

* Peer education;

* Self- esteem development;

* Generic needs assessment.

Clearly, in some cases there was cross over between activity. For example, outreach work might also involve training, or self- esteem development, or peer education. But I was able to interpret each report as having one clear activity focus; in some cases, further kinds of activity stemmed from this. It is interesting to note that the activities described and discussed by the writers as 'health promotion activities' broadly correspond with the kinds of things understood by my 'voices from theory' (in Chapters One and Four); and my 'voices from history' (in Chapters Two and Three). Up to this point, at least, it appears that in talking about 'health promotion', historical, theoretical and practitioner 'voices' are to some extent at least referring to the same kinds of things.

## 2. 3 The Reports and 'Settings' for Health Promotion

The writers were all discussing activity taking place in particular 'settings'. (I understand setting to mean either a catchment area for approaching a specific population group: or a locational framework for planning activity; or a combination of these (BARIC, 1996).) The settings were: local authorities; health authorities; NHS 'provider' Trusts; primary health care; schools; colleges of further education; voluntary organisations; and 'communities'- that is, a group of people bound by geography or some other defining interest (CALOUSTE GULBENKIAN FOUNDATION, 1984). Again, a writer might have been discussing work taking place in more than one setting (for example, primary health care and the community), although it was generally possible to identify a 'lead' setting.

Settings were almost always seen by the writers as neutral backdrops, against which activity problematic in itself was undertaken. For example:

*' The client may contact her GP surgery for advice but there is not any standardised advice given, and no requirement for practice nurses to become involved with the breast screening service since the service is contracted out to a local Breast Screening Service. So the next port of call is at the actual screening mobile where there is very little time for information giving. With a target to screen 60,000 women within three years, very little time is left for discussion at these busy screening mobiles.....'* (Sophie).

As Sophie continues to discuss, the activity of screening- at least in terms of how it was done here- caused her severe moral worries. However, the setting (in this case, primary health care and the community) did not appear to contribute to the difficulty.

Occasionally, a setting was identified as something more than a neutral background, but where this was so it was seen as a positive moral force, with the potential to convey and nurture the growth of appropriate values:

*'Schools.... are a place of safety and learning for young people, and often they are the most stable factor in a young persons life as more and more pupils come from unstable backgrounds. Young people while they are of school age spend more awake hours with their teachers than with parents or guardians during term time. Consequently the school setting has a big influence on young people during their formative years....'* (John).

## 2.4 Identifying Moral Doubt and Difficulty

Through my analysis, I identified four closely connected themes which represented the moral doubt and difficulty experienced by my participants:

* Diverse perceptions on the part of different people involved about the nature of health promotion priorities, needs and values;

* Competing views resulting from these diverse perceptions about what constitutes justifiable activity;

* A lack of shared understanding about the nature of concepts believed to be centrally important to the promotion of health;

* A lack of agreement about what constitutes acceptable knowledge of 'effectiveness' of activity when its potential for harm (or benefit) was being considered.

Each of these themes will be presented and discussed in more detail.

### 2.4.1 Diverse Perceptions of Priorities, Needs and Values

Perceptions of priorities, needs and values related to health promotion activity were seen by the writers to differ between: central government and local (health and local government) authorities; between practitioners and their managers; between practitioners from different disciplines or different fields of activity or with different interests; and between practitioners (as individuals and as representatives of organisations) and the people they served (patients, pupils, residents and so on).

Although this division between conflicting groups appears clear, in fact the nature and levels of conflict were rather harder to discern. For example:

*' The perception of substantial numbers of young people is that they can safely take drugs recreationally.... It is highly likely that the recipients of* [drug prevention] *messages do not see their drug use, if they do use drugs, as problematic....'* (David).

It is possible to identify two levels at least of actual or potential conflict here. First, between government ministers and part of the population they were elected to serve. For ministers (presumably), being healthy involves leading a drug - free life. For some or many young people, being healthy involves having a good time and a good time could include the use of drugs.

But there is also actual or potential conflict over priorities, needs and values between different people involved in constructing and then implementing the strategy about which David is writing- 'Tackling Drugs Together' (HER MAJESTY'S STATIONERY OFFICE, 1995):

*' During Drug Action Team and Tackling Drugs Together conferences in 1995 there hung in the air a strong shared feeling of- yes, this is all very laudable, but what are we supposed to be doing and how? The following quote from a colleague in a senior position in a local Social Services department seems to cut through much of the debate:*

*' " It's all such a lot of hot air isn't it?"....'* (David).

Government ministers and health and social care professionals in David's area might agree that misusing drugs does not constitute leading a healthy life. However, it is clear that a values dispute has the potential to emerge because of where and why the

initiative is placed on the map of priorities. So it can be seen that dispute may or may not actually or potential exist between any or all of the groups listed above; and in relation to any or all of the identified areas of priorities, needs and values. This is exemplified in a further account:

*' I would argue that the Sensible Drinking campaign is really only ultimately concerned with the prevention of disease. I would not deny that at times it may be appropriate to focus on a specific aspect of health, but I do not believe that we should lose sight of the person as a whole.... It is almost impossible to* [maintain a holistic perspective] *when dealing with a mass media campaign....'* (Liz).

Alison, who works as a lecturer in a college of further education, identified a particularly sharp values conflict as she was researching and writing about the college's no smoking policy. In an interview with the vice- principal:

*' He highlighted his concern about passive smoking and the worry of being sued by a student for ill - health in later years.* [He] *also hoped that the policy would lead to lower insurance premiums on the building and thus the college could save money....'* (Alison).

For Alison, her priorities and values (the importance of staff and student health) contrasted very sharply with the business values of the college management. Both parties might value ' health' (that is, not smoking), but their fundamental reasons for doing so differed dramatically.

Conflict over needs, priorities and values also occurred between practitioners. Sometimes these crossed disciplines. Judith, discussing smoking and pregnancy training, had approached local midwifery colleagues to talk about some of the issues raised by this kind of work:

*' I was unable* [to do so]..... *the Director of Midwifery was reluctant for me to talk to midwives for research purposes and also because she did not want me to produce any findings that may show midwives' practice in a negative light. This was despite my assurances that this was not my intention....'* (Judith).

It is possible to interpret this response as demonstrating values conflict in two different ways. First, the Director of Midwifery did not want discussion of the actual activity, suggesting her anticipation of actual or potential conflict over the nature and worth of the work itself. Second, that she evidently did not want such discussion might be understood as a reluctance in general to engage in the process of ethical deliberation. Thus there are separate views about the value of this kind of process.

Values conflict also existed between members of the **same** profession or occupation:

*'Not all teachers are against the principle of autonomy and respect for the pupils as people. Many try to put into practice* [their beliefs in the value of respect for autonomy]. *But just as I face conflicts of values with other health professionals in trying to implement my project, so do they in trying to share with other teachers the value of the work.. Within the project the only antagonism faced was with the teachers....'.* (Mandy).

Anthony demonstrated the significant chance of values conflict existing between the 'health professional' and her or his patients or clients. He was one of the minority of writers with direct 'patient' contact. Working as a clinical nurse specialist for HIV, he frequently had to counsel his patients about whether to embark on anti- HIV combination drug therapy. While such treatment might prevent disease progression and death, there is still considerable uncertainty about its effect long term (ALCORN

*et al*, 1998: CALDECOT CENTRE, 1997). Anthony was therefore in the position of having to ask himself:

*' Should I be encouraging patients to take anti - HIV drugs, or should I be encouraging self - empowerment/ autonomy...?'* (Anthony).

Of course, the autonomous patient might well not choose combination therapy:

*' G.... was vehemently opposed to taking zidovudine* [an anti- HIV combination therapy]. *However, while staying in London his symptoms of dementia became so severe that he was admitted to a hospital which, unaware of his view, started zidovudine. His improvement was rapid and remarkable but it was important to be truthful about his medication, even though he might have declined further treatment at a risk of allowing his dementia to return....'* (Anthony).

The potential for values conflict between Anthony as the health professional and G.... as the patient becomes disarmingly explicit in the following sentence:

*' It is illuminating for me to reflect that I would very much have regretted a decision by G.... to stop zidovudine, indicating to me a strong faith or value which I place upon anti - HIV drugs in certain circumstances....'* (Anthony).

The conflicts over priorities, needs and values identified so far has shown itself in engagements between organisations, hierarchies and people. Iris appears to demonstrate a different level of engagement. She is building a case for water fluoridation. In doing so, she tries to represent the argument as based on an incontrovertible body of dental public health knowledge. Local health authorities are unable or unwilling to respond to this, mainly she argues for reasons of finance:

*' Because of the number of sources of water supply, each requiring a fluoridation plant, and the low levels of tooth decay,* [fluoridating the supply] *would be "beyond the resources of the health authorities for the present". The most effective public health measure for preventing decay is being denied the residents of B.... on grounds of cost....'* (Iris).

The 'conflict' then is between supposedly objective epidemiological evidence and organisations far more preoccupied with economic considerations.

### 2.4.2 Competing Views about What Constitutes Justifiable Activity

In almost all of the writing analysed, it was possible to discern a tension between on the one hand the writer's perceptions about what counted as 'justifiable activity'; and on the other, those of their organisation or employer (usually represented by direct line managers). This tension emerged as a result of different views of what was valuable, and where needs and priorities actually lay. Carol, it will be remembered, was reflecting on sexual health outreach work with young people:

*' The outcome led emphasis of this work has moved me to question the ethics of the intervention and the perception held by purchasers of services that people are the means to an end, the end in this case being the achievement* [of] *targets. I feel that this is in direct conflict with my belief that health promotion needs to value processes and that people should be regarded as ends in themselves. Outcome led interventions based on perceived vulnerability as indicated by the AIDS Control Act (1987) could compromise autonomy....'* (Carol).

Carol's questioning was apparent from the beginning of her involvement with the activity but for Alison, the process of finding out more about the intervention she was

writing on led to the realisation that her values did not in fact correspond with those of the organisation. She begins her assignment:

*' Smoking is not an activity I participate in and when the college became officially designated a "Smoke- Free" Zone, I accepted this ruling without comment. Students and staff could stand outside the building to smoke and with the onset of the bad weather, they may choose to quit smoking, which would be better for everyone's health- including their own. I therefore accepted this paternalistic intervention without question.... '* (Alison).

But during the research for her writing, she discovers the motivation of management for introduction of the smoking policy. These were to avoid any future claims for passive smoking- related health damage by former students; and the desire to reduce the cost of buildings insurance premiums. After this discovery she writes:

*' I state again that the policy in its present format is unethical and ideally should be withdrawn....'* (Alison).

Thus the intervention (policy implementation) ceases to be justifiable to Alison.

Almost all of the writers were similarly concerned to demonstrate moral dubiousness about activities in which they had been directed by their organisation to engage. However, when a writer actually appeared to support a particular activity in an ethical sense, their defence of it was often highly elaborate. Julie was writing about peer education with young people. In the 'Socratic dialogue' forming the framework for her discussion, she counters moral arguments against this kind of activity- arguments around, for example, indoctrination and inequality of access:

' [The project is] *a very effective use of resources because* [it]*involves the development of skills, as well as the giving of information, and through the fieldwork a large number of young people are reached by the project....*

' *Young people have the right to relevant, accurate and understandable information which this project provides....*

' [The young people] *don't have to commit to the project until after the introductory day, which gives them time to think it over. They contact us if they want to go ahead and it is therefore concluded that they are willing to accept the responsibilities given them....'*

Even in this example of sustained and effective defence, it could be argued that its elaborateness conveys implicit recognition that the activity is not morally straightforward and could be regarded as 'difficult' or even by some as unjustifiable.

For at least one writer, **inaction** was as hard to justify as activity, even though intervening might be problematic:

' *My view is that legislation, including fluoridation, impinges on autonomy....* [However] *in the case of fluoridation, the benefits* [reduction of caries] *outweighs any impingement on autonomy....'* (Iris).

Whether an organisation was acting or not, the identification of competing values, priorities and needs almost invariably led to different views on the acceptability and justifiability of activity. Given the writers were all employed to act as directed, the discomfort in this exposing of tension is clear:

*' I have come to realise that my own values are often quite different to others who frequently have much more power, influence and ability to control than I do....'*
(David).

### 2.4.3 Lack of Shared Conceptual Understanding

Without exception, it is possible to identify in the writing a lack of shared conceptual understanding between the writers and others (for example, employers) which contributed to powerful senses of moral unease. Concepts about which the absence of shared understanding was clear included: health; health education; health promotion; autonomy; empowerment (including self- empowerment); personhood; and democracy. Frequently the concepts were seen as intimately connected, with lack of agreement spilling over from one to another. Conceptual muddle was never seen as an esoteric problem in itself, but as having a profound impact on practical activity.

Mandy, for example clearly saw 'health' as strongly linked to the concept of self - empowerment. 'Health' is that which the individual creates for herself or himself through becoming empowered. But she recognises this conceptualisation is often not shared by others:

*'Freedom to choose and health* [may be seen] *as incompatible, that is if you are empowered and you choose an "unhealthy" behaviour then the teacher and you have "failed". I disagree....'* (Mandy).

She continues:

*'What is happening* [through the project] *is a giving or developing of tools* [of empowerment], *how they use the tools is up to them. That is freedom.... We all have*

*different values as to what constitutes health so what is important is to give an individual the tools to create their own health....'* (Mandy).

Though as Mandy has already freely admitted, there are risks and disputes attached to this view of the nature of 'health'. Perhaps because they are acutely aware of difficulties attached to this and other relativist conceptions, many of the writers seemed wary of getting bogged down in detailed attempts to conceptualise health, referring vaguely to it as being *'holistic'* (Carol) and *'humanistic'* (Donna). Writers sometimes relied on 'official' definitions to carry them through- in particular those of the World Health Organisation (1946, 1984).

Some of the writers also saw 'education' as a disputable concept. Mandy noted two sharply contrasting views of education. For some it might be seen as encouraging:

*'Positive self - esteem....* [Producing those] *who can think critically, synthesise and transform, experiment and create....'* (Mandy).

But there is also:

*'Traditional education of rigidity, formal education....* [which encourages a] *move away from education that develops critically analytical people....'* (Mandy).

Mandy aligned herself with the first view. However, in declaring for a particular conceptual affiliation, it is apparent from what she has said above that this leads to the risk of dispute and moral difficulty, a point emphasised by Moira:

' [According to Freire] *"Education is either for domestication or liberation." The former accepts the values and norms of the culture and the latter where education for*

*liberation challenges students to think critically and challenge the status quo....'* (Moira).

It could be argued that the distinctions drawn by Freire in relation to education are paralleled within **health** education (and health promotion). Although neither Moira nor any of the other writers actually draw them, the parallels are with two competing models of health education and health promotion. These are on the one hand, the positivist and persuasive medical model; and on the other, the co-operative, relativist empowerment model. Many of the writers explicitly discuss these competing models in relation to the topic or activity about which they were reflecting, sometimes at length:

*' Case- control and longitudinal studies may reveal an association between increased alcohol consumption and decreased health which is then used as justification for a public health campaign. Health tends to be considered almost exclusively in its physical sense .... At the other end of the spectrum we have a model of health education which is derived from humanist theory. Humanists believe that people are autonomous and capable of self - determination.... Thus in any health education initiative, people rather than disease prevention become the focus of attention and the role of health educators is to empower. In its purest form it is left to the client to set the agenda and, therefore, the subject of alcohol may never be broached....'* (Liz).

It is important to note that Liz was so carefully drawing these distinctions at the time of the disease reduction- target driven 'The Health of the Nation' (SECRETARY OF STATE FOR HEALTH, 1992). It is highly likely that a group of health promotion practitioners committed to the empowerment model would find some tension in working to a strategy so clearly favouring the medical model. Indeed, the writers unanimously favoured the empowerment model:

*' I would suggest that my expertise.... is in helping patients to identify what is best for them. I cannot help patients.... unless I empower, enfranchise, listen.... '* (Anthony).

This translated into Anthony's particular practice:

*' I seek neither to encourage nor to discourage the use of anti - HIV drugs but to help patients clarify what is best for them.....'* (Anthony).

It has already been identified, however, that within his assignment Anthony actively reflected on the 'strong faith' he puts in anti- HIV drugs, suggesting again a tension between his own desire to operate according to an empowerment model; and the overwhelming dominance of the medical model within the health care system where he works.

The suggestion so far has been that lack of shared conceptual understanding exists particularly between health promotion practitioners and others who (either explicitly or implicitly) are controlling or directing their work. Moira, though, provided some empirical evidence underlining the existence of poor conceptual understanding or confusion **between** health promotion practitioners themselves. She undertook a small scale study exploring the understanding held by nurses in education of the concept of autonomy, and reported on the results:

*' Nine nurses gave the answer* [to the question, "What do you understand by autonomy?"] *"make own decision based on knowledge- responsible for own actions". Five said "having power over others", others said "freedom to offer the best choice for patients", "responsible for care of patients", "give power to the patient", "choice of an individual"....'* (Moira).

In undertaking her study, Moira was working on the hypothesis that if nurses and nurse educators possessed a clear understanding of the concept, they would be more likely to promote the autonomy of their patients. They would also be more likely to recognise circumstances in which individual autonomy was being breached. The identification of separate understandings suggests that what is seen as morally appropriate action and practice might well differ between the individuals sampled.

### 2.4.4 Lack of Agreement about what Constitutes Acceptable Knowledge of 'Effectiveness' of Activity when its Potential for Harm (or Benefit) was being Considered

The fourth theme discovered was connected to the belief expressed by most writers that if an activity could be seen as 'effective' (that is, if in some way it 'improved health'), then there was a greater chance that it could be adequately defended in a moral sense:

*' Promoting the well - being of patients is surely the purpose of my health promotion work....'* (Anthony).

The implication in Anthony's writing is that if an activity is 'effective' (that is, promoting of well- being), then it is supporting his purpose which is a moral one (at least in a *prima facie* sense). Julie writes:

*' Evaluations* [of the peer education and young people project] *are largely positive. The self - learning reported seems to indicate that young people have become more empowered and have increased self - esteem, as a result of being involved with the project....*

*' Empowerment is a health benefit....* ' (Julie).

The relationship between the project's activities and the young peoples' increased feelings of self- esteem and empowerment suggest to Julie that it is 'effective' and therefore morally defensible. This does of course depend on constructing 'health' as 'empowerment'. A central argument of this thesis so far is that both these concepts are deeply contested and the relationship between them strongly infused with problems. Inadvertently, perhaps, Mandy exposes the difficulty in relying on 'effectiveness' to confirm the morality of activity, simply because there is no single authentic version of health and consequently of 'effectiveness' in its promotion:

*' We all have different views as to what constitutes health so what is important is to give an individual the tools to create their own health, whatever that is for them and for us to feel comfortable with that....'* (Mandy).

But this pluralist approach (probably shared by significant numbers of people concerned to promote health) means that the simple equation, Activity plus 'Evidence of Effectiveness' equals Moral Activity, is implausible. Thus lack of agreement about what constitutes 'effectiveness' (and consequently about levels of harm or benefit emerging from activity) becomes a central part of the moral problematic facing the writers.

Arguably, tension resides in the commitment to pluralism. Leaving aside the conceptual difficulty in treating 'health' as simply the 'absence of disease', would it not be possible to claim greater moral justification for activity which actually reduced the incidence of illness or disease? Assessment of the activity's harm or benefit becomes clearer if- perhaps not unreasonably- it is supposed that 'more disease' is harm and 'less disease' is benefit.

Many of the writers were unhappy with this simplicity, in a general sense at least because of their distrust of the 'medical model' it represented. A focus on 'benefit' interpreted as 'disease reduction' might tempt policy makers and managers to endorse activity that was clearly difficult in an ethical sense. Sophie, writing about breast screening in her local health district, reported that she was working to targets of numbers of women to be screened (60,000 over three years). To her managers, if this target was achieved, she would be regarded as 'effective'. Yet:

' [With the target] *very little time is left for discussion* [of the issues and complexities associated with breast screening] *at these busy screening mobiles....* ' (Sophie).

Paradoxically for Sophie, screening interventions would take on a less mechanistic (and therefore more moral) form if the target wasn't being met!:

*' If screening uptake is particularly poor in a specific area, " all hell breaks loose"! Health promotion is called on in a big way to do something about it. Only then is any major effort and resources put into working on a grass roots level, through women's groups, churches etc.....'* (Sophie).

Worry about this background of frenetic activity and immutable targets, caused Sophie to return and reflect on difficulty with the evidence base for breast screening *per se*. From Skrabanek (1988), she writes:

*' Breast screening cannot prevent breast cancer, nor can it promise a cure; it is rather an attempt to gain better control over the disease....'* (Sophie).

Thus Sophie identifies rather more complexity in the notion that 'benefit' equals disease reduction. Applied naively, the idea may result in activities which fail to

respect autonomy and which in any case might not **actually** reduce disease (or at the least, their capacity in this respect could be disputed).

Liz also reflected on lack of agreement about 'evidence of effectiveness':

*' A recent development has been the publication of a government report on* Sensible Drinking *which reviews the drinking message (Department of Health, 1995)... One of the conclusions of the report was that* benchmarks for *sensible drinking should be redefined.... The conclusions of the report fly in the face of evidence from a number of medical bodies and individual experts including the British Medical Association.... and the Royal Colleges* [of Physicians, Psychiatrists and General Practitioners]....' (Liz).

What was only implicit in Sophie's writing- that constructions of 'evidence of effectiveness' and consequently notions of harm and benefit were strongly connected to policy and social context- becomes very clear in Liz's work:

*' The Chancellor of the Exchequer chose not to increase alcohol taxation in the November* [1995] *budget and actually decreased the price of spirits. However, presumably it was hoped this would be off - set by increasing consumption due to the new guidelines....*

*' Of course, there is another very influential player in this issue, namely, the drinks industry. It is well known that various breweries pay money into the Conservative Party's coffers although some big names actually withdrew their support in 1995....'* (Liz).

Finally, Anthony altered the focus of potential lack of agreement about acceptable knowledge of effectiveness away from professionals and policy makers. For him,

notions of harm and benefit, and consequent views on the value of activity. were deeply contestable, a mine field to be trod by patients themselves:

*' The spectrum of anti - HIV drugs which is available continues to expand. Patients- as well as clinicians- need to understand the mode of action, potential side - effects, problems of resistance, most effective combinations, optimum starting time, best sequence etc. of an array of nucleoside analogues, protease inhibitors and non - nucleoside reverse transcriptase inhibitors....*

*' Even within an orthodox western medical model the optimum time to start treatment with anti -HIV drugs is open to debate....'* (Anthony).

My analysis, then, reveals powerful strands of dispute about knowledge of 'effectiveness' in relation to the activities and practices discussed by my participants. In turn, this leads to the near impossibility of holding incontrovertible views about the levels of harm and benefit likely to accrue from a particular intervention. Recourse through such notions to simple moral defences of activity and practice cannot, then, work. (I would argue that this applies not just to those things my participants were describing, but to many other kinds of activities that could be called 'health promotion'. I will extend my argument in this respect in the following chapter.)

The argument against the possibility of taking a unified view of 'evidence of effectiveness' applies whatever view of health (and thus of health promotion) is adopted. Pluralists can most easily be seen to have difficulties, but as Sophie, Liz and Anthony demonstrated, the positivist medical model also faces problems. These emerge not only from competing individual and political preferences over interpretation, but also from the nature of the evidence itself.

## 3. Conclusion

In this chapter, I have listened to the 'voices' of my research participants as they have identified moral doubt and difficulty they believe to be associated with the activities in which they are involved. I have identified four intimately connected key themes which represent ethical problems and their nature: diverse perceptions of priorities, needs and values: competing views of what could be regarded as justifiable activity; lack of shared understanding of central concepts related to the promotion of health; and lack of agreement about what constitutes acceptable 'evidence of effectiveness' of activity.

In Chapter Nine, I return to my participants and consider the third question I am asking myself of their writing; how might it be possible to understand and deal with the tensions that have been identified? In asking this question- and as part of the answer- I more explicitly connect how they were writing (process) with what they were writing about (content). In doing so I construct, as part of my proposals for understanding and dealing with problems, a case for seeing the process of writing my participants have engaged in as providing an opportunity for understanding through reflection. Process and content are thus helpfully unified.

For the time being, however, I return to theory and consider the help it might offer to me in understanding and dealing with the moral problems of health promotion.

# CHAPTER SEVEN- RECONSTRUCTING HEALTH PROMOTION: CAN BIOETHICS HELP?

## 1. Introduction

I have so far argued that significant moral difficulties exist for health promotion as it appears to be understood conceptually and theoretically. Further, these theoretical difficulties are confirmed when considering the reflections on practice of those who participated in my 'empirical' research. Conceptualisations, theoretical constructions and activities identified as 'health promotion' have attached to them major ethical questions and doubt.

Simply to identify doubt, however, is not particularly helpful. Given many people are obliged, by virtue of their profession or occupation, to engage in activities with the aim of promoting health, it is unfair simply to raise the issue of moral risk and do no more. Besides:

'If we can really understand the problem, the answer will come out of it, because the answer is not separate from the problem....' (Krishnamurti, quoted in COHEN AND COHEN, 1980: 190).

Having prospected the territory this far, building on the understanding achieved up until now may lead to some sorts of 'answers' to the difficulties faced.

The rest of my thesis, then, is an exploration whose aim is at least that of increasing our capacity to deal with the moral problems presented by health promotion. There are essentially three stages in this exploration. The first is a review of the extent to which bioethics can support understanding, if not actual resolution of problems.

Bioethics may be interpreted as a genre of moral philosophy. It overlaps with another genre- that of professional ethics. In the second stage of my exploration, I review a broad and possibly convincing argument from within the genre of professional ethics for conceiving of professions as ethical. I consider the extent to which this kind of argument could be applied to those (health promotion specialists and health promoters) who 'do' health promotion work. While I assert there is some difficulty in application of the argument to this particular area of endeavour; nevertheless, in the third stage of my exploration, I propose taking account of it- along with aspects of bioethics- as 'markers' to be considered if health promotion is to be reconstructed in a moral sense. At this stage, I also listen again to the 'voices' of the practitioners whose writing I have analysed and consider how they have understood and dealt with the ethical problems they identified from their practice of health promotion.

To begin with, in this chapter I consider the help that might be offered by bioethics in a moral reconstruction of health promotion. I begin by describing and discussing the enterprise of bioethics. What is it? What is its purpose? How and why has it developed? I then move to consider the application of bioethics to health promotion. Finally, I develop arguments proposing that while bioethics can certainly offer important help to health promotion in understanding and dealing with the latter's moral difficulties; there are limits to the assistance it can provide.

## 2. The Bioethical Enterprise

I understand the bioethical enterprise to include areas of activity that others have called 'medical ethics': 'philosophical medical ethics'; and 'health care ethics'. It is possible to view the enterprise as essentially an analytic one in which the assumptions and values of those engaged in work to treat illness and restore and improve health are critically examined. Critical examination would extend beyond individual

assumptions and values to those of the systems in which people operate (either as receivers or givers of 'health care'). This initial description has been adapted from Gillon (1990b: 2). I use the terms 'the bioethical enterprise' and 'bioethics' as shorthand for the array of work implied by this sort of description. Above this array of work is the essential and overarching idea that the enterprise as a whole is one of conceptual and values analysis.

Of course, it cannot be denied that within this broad understanding there will be employed many different analytic techniques and approaches; and many different kinds of activities and interventions subject to analysis. As will become clear in the course of considering the material in this chapter, this is empirical fact. One issue to be raised later is the extent to which a particularly prominent, plausible approach of bioethics can be applied to activities that can be understood as 'health promotion'. For the time being, it is necessary to move forward on the basis that bioethics is the application of ethics- and of moral philosophical methods of conceptual enquiry- to health care practice and systems.

What then is ethics? In the history of western philosophy, two traditions have emerged, with alternative (though possibly overlapping) conceptions of the purpose of ethics. One tradition proposes that its purpose is the recommendation of life goals and the specification of ideals of personal excellence; of what it is to lead a good (valuable) life (FEINBERG, 1969; NORTON, 1976). The other suggests that the purpose of ethics is to determine in what sorts of ways we should act, and why; and to establish general obligations for action (LACEY, 1976). Arguably, the focus of the first tradition is on developing valuable individuals. In the second, the focus is on developing individuals whose conduct respects other individuals. I will later argue for distinctive difference between the traditions as they are represented in bioethics. However, it is possible to accept that they may be understood in some senses as overlapping. If I am attempting to develop my own valuable life, part of that project

will involve my undertaking certain obligations (for example, to educate myself). Equally, in recognising other lives as valuable, obligations will be placed on me as to how I treat those other lives.

In terms of the influence of meta- and normative ethical theories emerging from these broad traditions, it is the second- establishment of obligations for conduct- which has dominated, at least since the enlightenment. Flowing from the tradition suggesting the purpose of ethics is to frame obligations for conduct are first, deontology; and second, consequentialism. (As will be seen, these theories have widely differing views on the nature of moral obligation; it is thus necessary to be careful that framing them as flowing from the same tradition does not erroneously suggest a happy unity.) I will briefly introduce each of these theories but my main concern at this point in my thesis is to argue that because of their general influence in recent historical times, many of the roots of bioethical thinking lie in deontology and consequentialism. (Trying to establish bridges between them has, additionally, been a concern of some of the central figures in the bioethical enterprise.) While there has been some interest in developing the idea that the purpose of bioethics is to encourage the 'development of valuable lives', this has been very much of second order importance. I will return to this idea later on.

In the history of moral philosophy, the work of Immanuel Kant can be seen as paradigmatic of deontology- the brand of ethical theory concerned to argue that duty is the basis of moral action. Kant's theory is most importantly set out in 'The Groundwork of the Metaphysic of Morals' (PATON, 1948). His moral argument is intimately connected to his epistemology. For Kant, there exists a reality independent of the causal world. Evidence for the existence of this independent rational reality lies in his view that we possess the capacity to make choices (moral and otherwise) through free will; we are not helplessly subject to causation. Reason is thus the basis for moral action. Kant asserts that action is only moral if we are able to will that the

maxim underlying it is capable of becoming a universal moral law. Rational beings possess absolute moral value and are therefore entitled to be treated as 'ends in themselves' (and not means to ends). The only moral action is that which is based on the duty we owe to all other rational agents. Any other kind of action- for example, that based on thought of consequences- throws us back, helpless again, into the causal world.

Probably the best known version of consequentialist theory is utilitarianism. The most famous advocate of this is perhaps John Stuart Mill. Indeed, Mill's fundamental statement of utilitarianism has a resonance which comes from frequent exposure:

'Utility, or the greatest happiness principle, holds that actions are right in proportion as they tend to promote happiness, wrong as they tend to produce the reverse of happiness. By happiness is intended pleasure, and the absence of pain; by unhappiness, pain, and the privation of pleasure....' (MILL, 1962: 257).

As a normative theory of ethics, utilitarianism has been subject to particular refinement. For example, some of its supporters have argued that importance lies in considering the consequences of breaking or keeping to action- governing rules, as opposed to individual actions. Certainly in a normative sense this kind of refinement renders the theory rather less problematic (URMSON, 1967).

There are two starting points for my claim that the roots of the bioethical enterprise lie in deontological and consequentialist theory. The first lies in historical examination of the enterprise; and the second in what those working on it are actually doing and saying.

The practice of applying ethics to the 'real world' of professional and occupational action- a broad project within which the bioethical enterprise is highly significant- has

grown exponentially over roughly the last quarter century. (In writing about this phenomenon, I am confining myself in a geographical sense to the British Isles particularly.) For bioethics, this growth is demonstrated in several ways: through the rapid rise in numbers of 'health care ethics' courses: through growth in publications related to the area (for example, journals such as the 'Journal of Medical Ethics' and 'Health Care Analysis' were established within this period); and through proposals for the inclusion of ethics in the education and training curricula for health care workers such as nurses (ENGLISH NATIONAL BOARD, 1987); and doctors (GENERAL MEDICAL COUNCIL, 1993). This last policy direction has resulted in an increase in 'tools' to support the learning of health care professionals in relation to ethics and moral decision making (for example, SOAFER, 1995: VAUGHAN, 1999). More so in the United States than on this side of the Atlantic, there has developed a pattern of employing professional ethicists to support the moral decision making of hospitals and other health care institutions (GOROVITZ, 1990).

Taking Russell's view that philosophy and philosophers are both 'causes and effects' (RUSSELL, 1979: 7) of their social times; why did the bioethical enterprise emerge when it did? A number of connected reasons are suggested. First, health care in general and medicine in particular were beginning to be exposed, from the early 1970s onwards, to sustained scrutiny and objection in a way they had never previously experienced. Critics such as Illich (1977), Kennedy (1983) and McKeown (1976) challenged both the historical and scientific accuracy of viewing medicine as the bringer of health to the 20th Century; and the proposition that medical practice was an unassailable good.

I have already argued, in Chapter Two, that challenges such as these were key elements provoking the development of the so- called 'New Public Health' (and thus of the theoretical discussions and descriptions from which the idea of 'health promotion' emerged). Another of their effects was to make health care more open to

public questioning. It is argued that bioethics developed in part as a response to this questioning. (How it was used, by whom, and who can be seen to have received the most advantage in the playing of the 'bioethics card' are all interesting issues but outside the scope of this present narrative.) But doubt about medicine and health care was not related, simply, to elegant ideological or historiographical polemics on the worth of their practices. The practices themselves were rapidly changing- the second reason for the rise of bioethics. By the historical period under review, medicine had the technological capacity to end life, to sustain it, to begin and modify it (DWORKIN, 1995: HUMAN FERTILISATION AND EMBRYOLOGY AUTHORITY, 1994; KITCHER, 1997). Again, public worry about this seemingly unstoppable capacity and the challenge it provoked to traditional ways of understanding and respecting or valuing human life was an impetus to the development of bioethics.

The final reason for the rise of bioethics is possibly fortuitous and certainly pragmatic. Most prominent bioethicists- at least in the British Isles- are (or were) academic philosophers by trade (although some have emerged from professional health care backgrounds). Very arguably -and a point challenged by Maclean (1993)- a training in philosophy gives special expertise in thinking about moral matters. From the late 1970s onwards, many British university philosophy departments were under threat as a result of public expenditure reductions made by the then Conservative government. Potentially out- of- work philosophers- with their supposed expertise- were likely to be interested in a field where that expertise seemed to be called for by both professionals and the public. A body of academics with an eye on employability were available to write journal articles, present papers, design new courses and solicit for media attention. It is more than coincidence that the rise of bioethics occurred at about the same time as a period in the decline of 'traditional' philosophy departments in the United Kingdom.

These, then, are reasons for the emergence of the bioethical enterprise: the increasing critique of medicine and health care; concern over health care- generated technological change; and the crisis in philosophers' employment. And it is this history which provides the first support for the view that the roots of bioethics lie predominantly in consequentialist and deontological theory; meta- and normative ethics of obligation.

The challenge afforded by the critique of health care essentially implied (or actively advocated) limits to the power of professionals in this area (ILLICH, 1977). Concern to restrict more effectively aligns with 'obligation ethics' than with 'individual development ethics', at least at that point where there is crisis of confidence. Anxiety over technological change- fundamentally about changing our understanding of humanity- is again more likely to be met by considering obligations to (and restrictions on) action. (At a time when the nature of humanity is being challenged, it would arguably be much braver to ask questions related to 'individual development ethics' but also much less likely to happen.) Finally, if bioethicists are likely to be job-threatened philosophers, they will make the most of the expertise they have; supposedly an expertise in thinking about moral matters but, given the longer historical dominance of 'obligation ethics' already argued for, moral matters firmly in the context of consequentialist and deontological theory.

The second reason for my claim that the bioethical enterprise has its roots largely in theories of obligation lies in examination of what bioethicists generally say. Take the following statements made by some key proponents of the enterprise:

'[Scientific, technological, and social developments around the middle of the twentieth century] challenged many prevalent conceptions of the moral obligations of health professionals and society in meeting the needs of the sick and the injured. The objective of this book is to provide a framework for moral judgement and decision

making in the wake of these developments....' (BEAUCHAMP AND CHILDRESS, 1994: 3).

'Can we formulate any general principles to tell us which acts of killing, if any, are right and which are wrong? This is the central question of this book. But discussion of this problem is less fruitful when carried on in isolation from other related questions. Are there any general principles to tell us when, if ever, it is morally obligatory to save life....?' (GLOVER, 1977: 19).

'[ Philosophical medical ethics is] the analytic activity in which the concepts, assumptions, beliefs , attitudes, emotions, reasons and arguments underlying medico-moral decision- making are examined critically.... Its primary purpose is to construct a comprehensive and coherent moral theory for medical practice based on universal principles applying to all and capable of justifying particular lines of conduct in individual cases....' (GILLON, 1990b: 2).

'Individual interests and individual rights are the basic ingredients out of which the structure of morality is built.... Individuals are entitled to be and do as they see fit, so long as they do not violate the comparable rights of others....' (GOROVITZ, 1985: 36).

'Discussions about medical ethics tend to be not so much about what ought to be done or about what is being done as about the relationship between them....' (KARHAUSEN, 1987: 33).

It is important to note the tone of this writing as much as what is actually being said. Talk of 'critical examination', 'universal principles' and 'rights and entitlements' (with implicit reciprocal responsibilities) provides a sense that these key proponents of the bioethical enterprise are chiefly concerned with the justification of action in particular

ways, or the relationship between practice and responsibility. This is the territory of obligation ethics; Beauchamp and Childress and Glover all talk specifically of obligations. It is not particularly the territory of moral thinking based on the notion of the development of individual valuable lives.

John Harris (1985) appears to set out on a different track:

'This book, like the practice of medicine itself, is about the value of life....' (HARRIS, 1985: 1).

But not much later in 'The Value of Life', he writes:

'I have said that this book is about the value of life. I shall endeavour to present and defend an argument about how we are to understand just what it is to value life and about what is involved in respecting the lives of those we do conclude have valuable lives....' (HARRIS, 1985: 5).

If Harris's concern is to show the value of life, it is not so much to demonstrate how we can develop and lead such a life; but rather to establish the nature of the lives to which we ought to owe respect. In other words, we are back in the territory of moral obligation. His slipping from one to the other, however, is instructive as it demonstrates a point made towards the beginning of this chapter. The alternative purposes of ethics- development of the valuable life on the one hand and construction of obligations on the other- may well overlap.

Establishing that the roots of bioethics lie mainly in obligation theory- particularly consequentialism and deontology- is the beginning (as some of the quotations above have started to demonstrate) of identifying the sorts of projects in which the bioethics enterprise has been engaged. Bioethics in general has been concerned to establish

broad principles (capable of acceptance by as many as possible) by which professional action can be judged and to which health care professionals should adhere. Attempts have been made to reconcile the conflicting demands of consequentialism and deontology through such principles, in particular the so- called 'famous four' principles (BEAUCHAMP AND CHILDRESS, 1994: GILLON, 1990b; 1994; GILLON AND LLOYD, 1994; HARE, 1994). Others have tried to construct approaches to bioethics that are primarily consequentialist (HARRIS, 1985). Strong elements of deontology can be found particularly in work which attempts to assert the central place of the obligation to respect autonomy in health care actions (CAMPBELL, 1976: FAULDER, 1985; GOROVITZ, 1985). Consequentialism manifests itself in discussion particularly on health care resources allocation (CRISP, HOPE AND EBBS, 1996; GOROVITZ, 1994). Debate about obligation to action- stemming from commitment to either consequentialism or deontology- is frequently pursued in relation to specific issues such as the beginning and ends of life (DWORKIN, 1995; GLOVER, 1977). Discussion on the possibilities and limitations of codes of conduct as professional devices for understanding and committing to obligations of one sort or another is also a feature of the enterprise (EDGAR, 1994).

A further kind of project in which bioethics has been engaged is attempts at the clarification of concepts important to its apparent central purpose of determining and justifying obligations and conduct. Exactly what is understood by 'life' , 'death', what it is to be human and so on are all of concern to the bioethicist particularly as, in a descriptive sense, the nature of these things is being changed by powerful technologies (DWORKIN, 1995: HARRIS, 1985; KITCHER, 1997). There is also a tradition- which could be encompassed within bioethics- of conceptual examination of 'illness' and 'disease' (BOORSE, 1975: ENGLEHARDT, 1975, 1976; SCADDING, 1988); and of 'health' (HARE, 1986; SEEDHOUSE, 1986).

It is perhaps this broader project of conceptual examination which comes closest- in 'mainstream' bioethics- to the nature of the other ethical tradition identified earlier. That is to say, the tradition of recommending life goals and specifying ideals of personal excellence, of providing insight into what might constitute a good (valuable) life and how such a life might be led. After all, for example, if we agree that:

' Health is a goal which is desired universally....' (SEEDHOUSE, 1986: 10).

Then it makes sense to see the value of 'health' as one of the components of a good (valuable) life. Exploring and confirming the nature of the value might be one aspect of an enquiry into how the good life might be led. It has already been seen that assumptions about the nature of the value of health create a major flaw in the 'moral case' for health promotion. Shortly I will suggest that the field of activity's overall concern with obligation ethics has been at the expense of what could be a useful preoccupation with exploring values associated with the good life. Bioethics in general has had little such preoccupation.

Enquiry into the nature of the good life is a fundamental concern of Aristotle's Ethics (ARISTOTLE, 1955). Empiricism drives his argument that we become virtuous (and lead the good, or valuable, life) through performing virtuous actions. For Aristotle the virtuous action is the moderate action, leading to what Russell characterises as 'the doctrine of the golden mean' (RUSSELL, 1979: 186). Every virtue is a mean between two vices: for example, generosity is the mean between the two vices of, on the one hand, tight- fistedness; and on the other, profligacy. For Aristotle, while the identification of the virtuous in human action is of great concern, what is still more important is a commitment to reflection and contemplation in order that we can develop our lives so that we know how to act virtuously (morally). We thus become more 'expert' at being human, with reflection and consequent performance determining what it means to lead the good (valuable) life.

At this point it is possible to identify a significant difference between theories of obligation ethics (deontology and consequentialism); and Aristotelianism. Obligation theories are concerned to identify principles which should be followed as guides to right conduct. For such theories, virtue plays a secondary role in moral human action; it becomes something like having the right kind of general disposition which enables an individual to apply the 'right' ethical principle when required. Virtue is thus explained 'from the outside in' (DAWSON, 1994); we have the capacity to act morally because we know the principles and how to use them. The second order importance of virtue in obligation ethics is clear; if there were no principles, we would not be able to act morally because the disposition to virtue alone is not enough. (A reasonable extension of this interpretation is that without principles there would be no such thing as virtue.) For Aristotelianism, however, it is through development of the person (and her or his commitment to appropriate action through reflection) that virtue emerges. Virtue is thus explained 'from the inside out' (DAWSON, 1994).

A number of voices have argued that 'inside out'- Aristotelian- ethics should occupy a more central place in the bioethics enterprise. Haldane (1986), for example, makes a distinction between traditional conceptions of bioethics- what he terms 'ethics in medicine'- and the alternative approach of a genuine 'medical ethics':

'The application of general moral principles or ethical approaches to the special problems arising from medical treatment.... is best described as ***ethics in medicine***, rather than as ***medical ethics***, for it makes no claim to be a special kind of moral philosophy originating in examination of questions about the nature of health and its value. On the contrary it presupposes that the philosophy is developed independently and is then introduced into the consideration of particular issues....' (HALDANE. 1986: 145).

Haldane's alternative approach has as one of its central purposes the consideration of the kinds of questions of value he mentions. He argues for the Aristotelian idea of the human person as a 'unity- of- parts- in equilibrium' (body, mind and spirit). This metaphysics of the person implicitly rejects reductionism (one of the grounds of ethics in medicine); from its holism emerges the concern of Aristotelian ethical theory with the development of the valuable life. So:

'Medical ethics.... should be built around the attempt to answer two questions: *what is man* and *what constitutes goodness in life....* ' (HALDANE, 1986: 149).

Again, Fulford (1993), as part of a wider protest against the 'blindness' in some respects of bioethics, argues for it to engage itself more fully with clarification of value concepts; and from this, with broader philosophical theory, in particular philosophy of action. The implication here seems to be that in connecting values to action it will be possible to move towards an explanation of the part played by health in the valuable (moral) life.

This brief survey has no intention of being comprehensive; rather its purpose is to give an impression of the kinds of concerns and projects which appear to define the bioethical enterprise. The general impression is of a broad territory, nevertheless generally characterised by a desire to develop, understand and justify principles or obligations on which to base or defend action. Even those who assert the problematic in this kind of project (for example, MACLEAN, 1993) can be seen as committed to the bioethical enterprise. In the case of Maclean, the commitment is to liberate its projects from the grip of professional philosophers (her arguments will be returned to later). Doubtless 'anti- bioethicists' such as Maclean would find equal problem with the sorts of Aristotelian notions of the purpose of the enterprise that I have just described. It is clear, however, that these alternative ideas of purpose are of second

order importance to the dominant concerns of bioethics and its primary relationship to ethics of obligation.

### 3. The Application of Bioethics to Health Promotion

It is now possible to move to the territory of bioethics as applied to health promotion. To begin with, however, a general question needs to be raised which should actually help to begin to introduce the nature of the territory. One of my methods in the construction of this thesis has been to try and listen to different 'voices' as a way of understanding what might be meant by the nebulous and contested idea of 'health promotion'. This has been at least in part so that I am prevented from undertaking my own artful construction of health promotion and thus rendering it more problematic in a moral sense. My arguments have been based on what both theorists and practitioners have actually said. The voices have had a mediating function to some extent.

I continue to listen to voices in this section of my work and now I am mostly hearing professional moral philosophers and applied ethicists. But it is important to remark that- with just one or two notable exceptions- I am hearing a different set of voices. It seems as if the people who are articulating the moral problems of health promotion are not the same as those who have engaged in its theoretical construction.

I do not intend to explore in detail why this should be the case. There is, though, much of potential interest here. Is it because the academic traditions of health promotion and of philosophy are particularly difficult to cross? If there is this difficulty, does it relate to the existence of skills deficits and a belief that these would be hard to rectify? Or is it because of a more general and possibly deeper seated reluctance to cross between the traditions? These are particularly interesting questions

given my suggestion that both health promotion and bioethics can be interpreted as emerging, from a historical perspective, as new paradigms; and this emergence following cumulative unease with the paradigm represented by traditional medicine. If they emerged together, as it were, how and why have they had so little to do with each other?

I have to turn from these interesting questions to one that is rather more fundamental to my project. Assuming the voices from health promotion on the one hand, and those from bioethics applied to this on the other, are by and large different; how can I be confident that they are talking about the same thing? Is there the possibility that bioethicists- for this is who they mainly are- have constructed a deliberately morally problematic version of health promotion in order that they can wage a fruitful 'cold war' against it?

Broadly, there are two ways in which bioethics has been applied to health promotion. (This classification should not be seen as watertight. Some work, of course, crosses the boundaries I have artificially created for mapping purposes.) First, there have been projects attempting to assert and map out in detail the values believed by their authors to be important to this field. These kinds of attempts at understanding (and even constructing) values generally align more easily with Aristotelian conceptions of the purpose of morality- understanding what it is to lead a good (valuable) life. Downie, Tannahill and Tannahill, for example, specifically identify a major part of their purpose in 'Health Promotion: Models and Values' (DOWNIE, TANNAHILL AND TANNAHILL, 1996) as analysis of the nature of values and valuing: the nature of values necessary if an individual or a society are going to flourish; and the bearing of health promotion on such values. In common with bioethics in general, these Aristotelian- like projects tend to have had significantly less energy applied to them. (As will be seen, they also stray rather easily into the territory of obligation.)

The second way is through the more particular expression of obligations, most often by reference to action- guiding principles, and the application of these to very specific activities. (See, for example, Gillon (1990a).)

Given these different ways in which bioethics has been applied to health promotion, I return to the question I posed: is there the possibility that bioethicists have constructed a deliberately ethically difficult version of health promotion in order that they can besiege it? In terms of the first, value- mapping, way. What these bioethicists are essentially doing, I will shortly argue, is describing or constructing values in order to justify a particular position on health promotion. They are actually using bioethics (and of course its techniques) in order to state preferences about what health promotion is and how it should be conducted. Indeed, one prominent set of theorists engaged in this kind of project has already been reviewed as a contributor to the 'moral case' for health promotion set out and deconstructed in Chapter Four (DOWNIE, TANNAHILL AND TANNAHILL, 1996). If those engaged in this sort of project are besiegers, it is with the purpose of claiming more ground for their own version of health promotion. Given the contestability in general of the field, it seems unfair to claim that bioethicists constructing versions of health promotion (or those using bioethical techniques in order to do so) are building anything more or less 'authentic' than are health promotion theorists.

As for the second way. Here, specific activities are assessed against frameworks of principles, usually representative of obligations. Examples of particular activities discussed include screening (SHICKLE AND CHADWICK, 1994): health education advice giving in primary health care (GILLON, 1990a; DUNCAN AND CRIBB, 1996); legislative and policy activity for the promotion of health (WIKLER, 1978: 1987); and HIV prevention and care (WESTRIN *et al*, 1992). These bioethicists are examining a range of activities sounding very much like many of those spoken about by my practitioner participants. How Shickle and Chadwick describe screening, for

example, draws attention back to the voice of Sophie who it will be remembered wrote about problems attached to a population approach to breast screening. It does not appear, then, that the bioethicists are inventing an unusual- or an unusually problematic- set of activities.

It therefore seems there is little ground to believe the bioethics enterprise has artfully reconstructed health promotion so that the field has become more ethically difficult than in reality it is. The question now is: can the work of bioethicists help in dealing with the moral problems of health promotion?

In Chapter Four, I set out a 'moral case' for health promotion. This had three components: first, that health was a value; second, that the goal of health promotion was 'more health'; and third, that health promotion's key strategy of empowerment increases both the likelihood of 'more health' being achieved and the morality of activity. In essence those engaged in health promotion, the case claimed, were both pursuing a valuable (moral) goal and undertaking this pursuit in ethically acceptable ways.

I challenged this theoretical case. I argued against its first component by asserting that the nature of the value of health was problematic and disputed. Those engaged in health promotion work had a tendency to view its status as a value as overriding, when sometimes- possibly often- this wasn't the case. I disagreed with the idea that the goal of health promotion was 'more health': partly because there was difficulty in identifying one uniformly acceptable account of 'health' (professional and lay conceptions, for example, may differ); and partly because those controlling or with an interest in health promotion might actually be pursuing 'non- health' goals (such as economic advantage). I argued against the uncomplicated position health promotion theorists took on the strategy of empowerment; there will always be problems

attached to supposed transfers of power, partly because these are undertaken in contexts laden with values.

I then moved from the theoretical and sought the views of practitioners on ethical difficulties associated with the activities in which they were engaged. These appeared to confirm my theoretical worries. My participants felt moral unease because they had different perceptions of the nature of health promotion priorities, needs and values to others- particularly powerful others such as managers and those with political influence. These diverse perceptions led to competing views between practitioners and others as to what constituted acceptable and justifiable activity- and also of what ought to be understood by 'effectiveness' and 'knowledge of effectiveness'. Further, my participants were worried in a moral sense because there seemed to be a lack of shared understanding (between themselves and others) as to the nature of the concepts believed to be centrally important in the promotion of health (for example, 'autonomy', 'empowerment' and indeed 'health' itself).

Can then bioethics help in dealing with these difficulties? At first glance, it appears that it might be able to do so. I have identified two ways in which bioethics has been applied to health promotion. First, through the mapping or construction of values important to the field: and second, through developing and applying principles (to be seen as expressions of moral obligation) to particular activities. Given the nature of my moral worries, attempts to become clear about values, assumptions and the problematic within activities might be seen in a general sense as very helpful. But exactly how helpful? My plan now is to assess the use of each of these ways of applying bioethics to health promotion to my theoretically and empirically based statement of the field's moral difficulties.

## 3.1 Attempts to Map or Construct Values Believed to be Important to the Field of Health Promotion

A number of writers have attempted to map, construct or clarify the values that appear to be important to the field of health promotion and their nature. These include Campbell (1976, 1990), Cribb (1993), Cribb and Dines (1993), Dougherty (1993), Nordenfelt (1993) and Yeo (1993). Much of this sort of writing demonstrates a general belief in the value of health, then proceeds to construct an account of- and justification for- other values contingent on this general belief, together with a description of what acceptance of these values might imply for how health promotion work is done. Campbell (1976), for example, argues (from Illich) that health is contingent on the presence of freedom (autonomy). Thus strategies for health should be centred around attempts to enhance freedom. Campbell sees this being achieved largely through processes of education. Yeo (1993), as was discussed in Chapter Four, argues for the centrality of freedom to both individuals and communities if they are to be perceived as 'healthy'. This kind of work again represents the possibility of overlap between 'valuable lives' (Aristotelian) and obligation (deontological or utilitarian) ethics. I am obliged to respect the freedom of individuals and communities because in doing so I will be contributing to the creation of healthy (valuable) lives.

There is undoubted worth in these contributions to the bioethical enterprise. Their general orientation is educational rather than problem- solving. They are not about seeking answers to specific difficulties emerging from the practice of health care; but rather about raising awareness of the sorts and nature of the values that ought to be occupying those engaged in this field. One of the key difficulties that I have identified in my theoretical and empirical work is that the nature of the value of health is often disputed. This is represented in the existence of diverse perceptions (between, say, practitioners and managers) as to what constitutes health promotion priorities, needs and values (and thus what might be seen as justifiable activity). It seems there is at

least the possibility that this particular orientation of the bioethical enterprise- towards clarifying, and educating about, values and their nature- might support understanding of this particular problematic I have identified.

To determine more specifically the helpfulness of bioethics in this respect, I want to examine in detail two accounts from the enterprise of health and the nature of its value. They are those of Downie, Tannahill and Tannahill (1996); and Seedhouse (1986, 1988, 1997). As well as choosing these because they look as if they might help in the difficulties I have identified, I am examining them because in both cases the ultimate purpose of the theorists is to present and justify an account of health promotion which they believe renders the field ethical. The nature of the value of health thus becomes integral to the value of the health promotion project. Both accounts are also widely influential among practitioners. As a major concern in this research has been to listen to practitioners' 'voices', it is sensible also to try and understand theoretical work important to them. It will be remembered that part of Downie *et al* 's argument was deconstructed in Chapter Four, as an element of my own position against the putative 'moral case'. I return to this now with a more developed understanding of the problematic and to see whether- in a Krishnamurti-like sense- their writing might also hold an element of the 'solution'.

The arguments of Downie *et al* and Seedhouse are in many respects quite similar. Both can be seen as beginning with the assertion that ethics (Seedhouse) or values (Downie *et al*) form a fundamental part of the fabric of human lives and relationships:

' "Ethical" and "moral" are words whose significance and meaning enter into all areas of human thought and action.... The range of issues that have implications for ethics is immense and varied....' (SEEDHOUSE, 1988: 18).

Seedhouse distinguishes between different types of ethics: dramatic (specific) ethics: persisting ethics (the continuing underlying issues); and ethics in the general sense (ever present and returning questions such as 'How should I live and act?') (SEEDHOUSE, 1988: 20). Those working in health care have their attention claimed- if at all- by dramatic ethics at the expense of any continual examination of ethical purpose and of development in a moral sense. Thus 'ethics' and 'ethical thinking' become compartmentalised and rarefied, and we require experts to tell us what in a moral sense we should do (SEEDHOUSE, 1988: 117). Both Seedhouse and Downie *et al* want to rescue moral debate from being the exclusive preserve of experts. For the latter writers, this concern has strongly influenced their choice of language in the argument they are making:

'We shall use the terms "values" and "value judgement"....[because] it brings out the continuity between the values encountered in ordinary life and those encountered in the professional practice of health promotion....' (DOWNIE, TANNAHILL AND TANNAHILL, 1996: 154).

This shared view between the writers on the all- pervasiveness of ethics or values- and their belief that turning to 'experts' cannot be enough- is helpful. It locates health promotion firmly in the territory of values. Unless values or ethical beliefs are held unanimously- which is unlikely, particularly given the differences that have emerged in the accounts of history and theory given in this thesis- there is bound to be moral dispute. Assertions by these writers on the central place of (probably disputed) values gives strength to a project of moral examination. Both Downie *et al* and Seedhouse go further, however. They suggest that values **drive** health promotion practice, although the extent to which they do so is a point of difference between the writers:

'Sometimes it is said that traditional medicine and health care are scientific and based on fact, whereas health promotion is moralistic.... the truth is that *both* medicine *and*

health promotion have a scientific basis, and *both* deal with prescriptions for improving the quality of life.... Both points of view strive to be scientific, but neither is value- neutral....' (DOWNIE, TANNAHILL AND TANNAHILL, 1996: 116-117).

The impression is of two fields struggling to be rational in the context of values-related debate and disagreement. The issue implied by what Downie *et al* suggest, however, might lead to a rather more forceful conclusion about the value- laden nature of medicine and of health promotion. What exactly are these 'prescriptions for improving the quality of life'? What is 'the quality of life' anyway? Trying to define and describe these is unlikely to be wholly a rational project, as has been evident throughout this thesis. It might not even be rational at all, a more radical position taken by Seedhouse which starts to distinguish him from Downie *et al*:

'*Values drive health promotion*- people's values *determine* what is taken to be good or bad health: health promoters' values set health promotion priorities, health priorities do not set themselves....' (SEEDHOUSE, 1997: 69).

If that is the case, the question now becomes: What values should drive health promotion? In terms of my own moral worries and those of my research participants, a reasonable answer to this question is fundamental. If it can be found, then I may be reassured of possible resolutions to two central aspects of my theoretical moral case against the field: namely that it is not enough to rely on 'more health' justifications for health promotion; and that we need to expose the nature of both 'health' and 'non-health' values. (It is necessary to remember that 'non- health' values driving particular activity might be perfectly reasonable. The problem at the moment is that we do not have a rationale for accepting any as such.) Further, answering the question may help my research participants, particularly with regard to their key concerns over the diversity of values: which of these are justifiable in a moral sense; and what, following on from this, might therefore be seen as justifiable activity?

My initial assessment, in Chapter Four, of Downie *et al's* argument suggested that it was problematic. Broadly, they propose that there are a set of 'necessary social values' (DOWNIE, TANNAHILL AND TANNAHILL, 1996: 158) which are such because they respond to deep seated human needs and nature. For example, stemming from human vulnerability to disease is the value of physical integrity and health, from which in turn might be derived a moral principle based on the requirement not to harm others, either physically or psychologically. Further, there is a set of 'necessary individual or personal values' (DOWNIE, TANNAHILL AND TANNAHILL, 1996: 161) which are important if an individual is to have a flourishing life. The potential, at least, to be self- actualising might be one of these and again from this might be derived a moral principle based on the requirement to allow people as far as possible the capacity to act and develop autonomously. In sum:

'The values are the source of the empowerment which constitutes true societal well-being....' (DOWNIE, TANNAHILL AND TANNAHILL, 1996: 167).

Downie *et al* have earlier made it clear that 'well- being' is health in its positive form (DOWNIE, TANNAHILL AND TANNAHILL, 1996: 18). Thus there are a set of necessary social and personal values to which we should adhere if we wish to see individual and societal health. To give them due, they have been explicit about what these are. My objection in Chapter Four to their argument was in relation to their implicit claim that these 'contributing to well- being values' were overriding. Thus they were not that far removed from the very problematic position of suggesting that the value of health is always and absolutely overriding.

I suggest that there is still a difficulty in accepting the necessary nature of the particular **set of values** proposed by Downie *et al.* I could construct an alternative set based on a different conception of society and individual need and argue that these are

necessary. For example, I could be motivated by the view that human beings are primarily driven by a desire for order and security which might lead to the possibility that being looked after is a value. This in turn might give rise to the moral principle that I should always act paternalistically. The point is that there are competing views of the nature of humanity and human well- being. Given this, others with alternative views could reject and replace those advocated by Downie *et al.*

However, given the more detailed picture of the nature of moral problems that I have now built up, Downie *et al* do offer help in an important respect. I and my participants have identified worry about the possibility of competing, 'non- health' goals for health promotion work, leading in turn to possible conflict about what might be justifiable activity. The argument reviewed here suggests a 'long list' of values that might be connected to health; using this might help us more effectively to discriminate between 'health' and 'non- health' goals for health promotion work. This is a more limited, but more reasonable, claim than to suggest that there is only a short set of health- related values.

If Downie *et al* cannot be found to be wholly helpful in responding to theoretical and practical concerns raised in relation to the nature of health as a value- in particular, the perception by some at any rate that it is overriding- it is at least partly because of the way in which they understand the relationship between necessary social values and necessary personal values. They argue that both kinds of values hold claims on us. Social values hold claims which, if we ignore them, lead to:

'....Threats of disharmonious and uncooperative social relationships. Analogously, the constraints which make individual values claims are the threats of disharmony and disintegration within the self.... A sense of coherence and self- esteem, and therefore of true well- being, come from the awareness that the personal values we have

mentioned are being expressed in a way of life....' (DOWNIE, TANNAHILL AND TANNAHILL, 1996: 166).

Thus, personal and social values are linked because of the need to 'respect human nature whether in your own person or that of another....' (DOWNIE, TANNAHILL AND TANNAHILL, 1996: 166). If we do not, both the fabric of society, and individuals within it, suffer (and of course, given what has been said before, part of this suffering is connected to health).

However, this view that necessary social and necessary individual values tend to align is somewhat bald. Remember, for example, Sophie, whose writing on breast screening was described in Chapter Six. Those controlling the screening programme were driven by values, and it may be that these related to Downie *et al*'s typology- say, for example, the value of fair distribution of health care burdens. But as Sophie graphically recounted, this driven programme may well have conflicted with individual values and individual autonomy (which also have an important place in the Downie *et al* framework). This led her to question the justifiability of the activity. In terms of the theoretical argument I presented in Chapter Four, the work of Downie *et al* may not have moved us very far in terms of addressing the problem of empowerment and autonomy in the field of health promotion. Who should have the power, why and with what limits? (Of course, given the preliminary remarks to this section that I made above, there is a need to suggest that Downie *et al* cannot necessarily be held responsible for this particular failure to move forward; their project is not explicitly one of problem- solving.)

The potential for health- related values conflict in Downie *et al*'s argument may emerge because we fail to agree on the relative importance of the multiple values they describe: on the one hand, to society; and on the other, to individuals. Would it be better instead to concentrate on establishing a single view of the value of health itself.

then working out the values and principles that might flow, for both society and individuals, from this view? I have so far been sceptical about projects concerned to give a single authoritative account of health. This, however, is the direction taken by Seedhouse and which I now want to explore.

His argument, begun in 'Health: The Foundations for Achievement' (SEEDHOUSE, 1986) works from a number of premises: that the concept of health is contested; that existing theories of health centre around the removal of obstacles to human potential; and that these obstacles extend well beyond narrow biological and medical boundaries. Thus:

'Work for health is essentially *enabling*. It is a question of providing the appropriate foundations to enable the achievement of personal and group potentials. Health in its different degrees is created by removing obstacles and by providing the basic means by which biological and chosen goals can be achieved.... *A person's optimum state of health is equivalent to the set of conditions which enable a person to work to fulfil his or her realistic chosen and biological potentials. Some of these conditions are of the highest importance for all people. Others are variable dependent upon individual abilities and circumstances....*' (SEEDHOUSE, 1986: 61).

From this view of health- against the background of Seedhouse's ever present claim that it is values which drive work for health care (including health promotion)- it becomes clear that we must value specifically those things likely to support the creation of the foundations for achievement. Key within this is the value of autonomy:

'A study of the practice and theory of health shows the extent to which autonomy is central to health work. The idea is such an abiding feature that it makes nonsense of

claims that autonomy has no part to play in work for health....' (SEEDHOUSE, 1988: 131).

We must, therefore, aim both to create and to respect autonomy. These are central values for work in health promotion. At this point in Seedhouse's argument, however, we run into problems. Doesn't it simply face the same difficulties as Downie *et al*'s did? When and why do we limit autonomy? Or do we never do so? If we accept the second proposition, how is it possible to understand the sort of sentiments expressed by Anthony earlier on in this thesis:

*' Should I be encouraging patients to take anti- HIV drugs, or should I be encouraging self- empowerment/ autonomy....?'* (Anthony).

Seedhouse, I argue, would respond to the dilemma posed by Anthony as follows. From the broad view of influences on health suggested by empirical and conceptual work, it is possible to identify a range of 'blocks' that might constitute the foundations for achievement (that is to say, health) in any one case (SEEDHOUSE, 1997: 142). If, in the example described by Anthony, a 'block' is missing (something like, say, cognitive capacity), then work to restore or repair that block is 'work for health' because it is work to fulfil worthwhile potentials. Other things being equal, then, the block should be restored (adapted from Seedhouse, 1997: 152). The implication of this position- accepting that drugs will help restore the block- is that they should be given, possibly at the expense of the immediate autonomy of the patient.

Seedhouse freely acknowledges that the foundations theory of health and of health promotion, together with the associated tool of the 'ethical grid' (SEEDHOUSE, 1988) may not provide absolute answers or definitive directions. There are always alternative possibilities. But those possibilities will only be to do with health, and

therefore moral, if they are directed towards creating or repairing the foundations for achievement.

It is clear that in some respects Seedhouse's argument is helpful in the ethical reconstruction of health promotion. By more closely determining the nature of the value of health, it is possible to identify circumstances in which action in the name of health may not be such at all. It may be helpful to suggest that health does in fact have overriding value if those involved in a particular health promotion activity recognise it is foundations creating or restoring. (Should there be disagreement about this, say between client and professional, then the foundations theory provides the opportunity for debate and discussion.) Consequently, as claimed (SEEDHOUSE, 1997), it could be the case that the theory allows practitioners to make sensible judgements about what actually constitutes justifiable activity.

But there are difficulties with Seedhouse's argument. Problems appear to me to revolve around two important, and related, issues: the culture in which application of the foundations theory is likely to be attempted; and the disposition of individuals within that culture.

In Chapters Two and Three, I presented a history of the field of health promotion which located it, broadly, in a political world often dominated by the overwhelmingly powerful profession of medicine. Clearly driven by values, medicine attempts to frame itself as objectivist and scientific. In recent years, the power of this profession has been challenged, although with limited success. The most sustained challenge to the dominance of medicine in the field of health has been from those (arguably equally eager to frame themselves as scientific and objectivist) who perceive it as more socially constructed and determined. Generally, both the 'medical modeller' and the 'social modeller' view their competing practices as authentic and strive for control

of health. This extends to projects aimed at professionalising health promotion itself: or appropriating health promotion work more effectively into existing professions.

The actual extent of this work is significant and raises an important question for Seedhouse's theory: to what degree is it likely to be possible for identification of, and negotiation of work on, individual foundations of achievement in a world gripped by the power of professions and competing paradigms of health? Even if agreement could be reached between individuals, how far could work and outcomes potentially very different from those suggested by the dominant paradigms be allowed by those professionals ultimately in control?

This leads to the second difficulty. In an important sense, Seedhouse's argument is about individuals (health care workers and clients) having the right kinds of disposition (or at the very least, the right sorts of attitude): to recognise that all their ideas and actions have moral importance; to recognise the nature of the values with which they are confronted and of those which should be fundamental to them; and to recognise the foundations for achievement required in particular cases. Yet the cultural context in which individuals work may not allow them the opportunity to develop these dispositions or attitudes. The training of professionals is frequently oriented towards the technical and enabling them to deal with specific problems of practice (SCHON, 1990). Development of moral disposition or attitude may be relatively unimportant. If this is so, then it may be hard to acquire the disposition that enables someone, for example, to determine the morality of a course of action potentially capable of disrupting autonomy in the short term but with the long term effect of enhancing it through creating or supporting the 'foundations for achievement'.

In summary, then, these significant projects I have reviewed which aim to map or construct the values central to the field of health promotion are useful in the following

respects. They identify the centrality of values to the field (something that previous 'voices' from health promotion theory to which I was listening did not do). They propose particular values important to the field and attempt to establish a rationale for committing to those values (although as I have indicated, not without difficulty). However, they are not particularly successful at justifying particular courses of action in the case of conflicts (Downie *et al*); or at resolving the tension between disposition and what is required by professional and cultural context (Seedhouse). Of course, as I have consistently reminded myself, these sorts of projects have not oriented themselves particularly to problem- solving, especially in relation to particular activities or aspects of practice. Yet as my participants in Chapter Six made clear, specific problems are faced by those engaged in the field of health promotion. Does another sort of way bioethics has been applied to health promotion- the application of principles (as expressions of obligation) to particular activity- offer greater help in understanding and dealing with these kinds of problems?

### 3.2 The Application of Principles (as Expressions of Obligation) to Particular Activity

This approach on the part of bioethics to health promotion has arguably been a great deal more significant than that of values mapping or construction. It is possible to detect roots of obligation in much of the bioethical literature on health promotion. Even the writers discussed above- who have been presented as strongly concerned with determining the nature of values and valuing in relation to the field- can be interpreted as doing so at least partly in order to determine obligations. Thus Seedhouse constructs his 'ethical grid' (SEEDHOUSE, 1988). Although he attempts to present this as 'a practical and accessible route into the complexity of moral reasoning' (SEEDHOUSE, 1988: 128)- no mention of obligation here- it becomes clear as it is unpacked that it is a 'tool' with a strong function in this respect:

'The *requirement* to respect persons equally when working for health follows from the *requirement* to create and respect autonomy in all people....' (SEEDHOUSE, 1988: 132, my italics).

Equally for Downie *et al*, values lead to obligations:

'We shall consider how these values and *principles of social life* are or ought to be the *guiding principles* or "ethics" of health promotion in various social, personal and educational contexts....' (DOWNIE, TANNAHILL AND TANNAHILL, 1996: 161, my italics).

These kinds of statements are representative of the difficulty in disconnecting the project of values mapping from that of principles and obligations application. I would not dispute that the two projects are connected. However, I think there is worth and importance in treating them separately. The kind of work that for example Seedhouse and Downie *et al* are engaged in can be aligned much more closely with the 'inside out' view of morality described above. To various degrees, they are attempting to establish values (and from these, obligations) based on their understanding of what it is to be human. The work under review now has quite different characteristics and can broadly be aligned with an 'outside in' view of morality. An example from the literature of 'the ethics of obligation' will help to make the difference clear:

'At present, State or private bodies conducting mass preventive interventions have no obligation to inform the healthy participants that they are subjects of experiments of uncertain outcome and potential harm.... For example, in the Breast Cancer Detection Project set up in 1973 by the National Cancer Institute and the American Cancer Society to screen a quarter of a million healthy women, the possible risks of mammography were not explained to them nor were they told about the lack of

evidence for the benefit of mammography in women under the age of fifty. In subsequent similar trials in different countries, no mention was made in the published reports whether the participants received adequate information about the uncertainties of benefit. Such information could, of course, jeopardise the "compliance" rate and the "throughput"....' (SKRABANEK, 1990: 187).

It is clear that for Skrabanek, 'benefit' and 'harm' are important **moral** qualities that could be translated into principles or obligations; 'act in such ways that you only produce benefit' and 'do no harm', for example. And while it could be argued that such obligations emerge from an analysis of human nature and the values important to us (here, avoiding harm and receiving benefit), there is no evidence of such analysis having been undertaken. Harm avoidance and benefit production simply are 'medico-moral norms' (SKRABANEK, 1990: 189) to which professionals should commit. (Of course the fact that, according to Skrabanek, they are not being treated seriously by those whose activities he describes is cause for ethical condemnation.)

This 'outside in' assessment of the morality of health promotion activity can be seen in the work of a number of other writers as well as Skrabanek (GILLON, 1990b: KELLY, 1996; SHICKLE AND CHADWICK, 1994; WIKLER, 1978, 1987; WESTRIN *et al*, 1992; WILLIAMS, 1986). Attempts to establish which 'outside in' principles (and obligations) are important to the field of health promotion have been more or less specific. An example of a broad approach, citing and defending rather general principles can be found in Gillon (1990b). Somewhere further along an 'obligations continuum' it would be possible to place attempts to develop 'codes of conduct' for health promotion work (KELLY, 1996: SOCIETY OF HEALTH EDUCATION AND HEALTH PROMOTION SPECIALISTS, 1993, 1997b). It will be remembered that attempts to develop such a code were part of the broader effort to 'professionalise' the occupation of specialist health promotion described in Chapter Three.

My intention now is to review a particular project along this putative 'obligations continuum' and discuss the extent to which it might be helpful in supporting any attempt at the moral reconstruction of health promotion. This is the so-called ' four principles of health care ethics' approach to ethical problems in health care.

From the range of ways in which principles (as expressions of obligation) have been applied to the field, it is important to justify selection of this project. Choice of the so-called 'four principles approach' is because it is widely acknowledged as providing the basis of ethical guidance for many working in health care. Writing in the British Medical Journal (BMJ), its foremost British exponent provides a sense of the breadth of acceptability of the principles:

'Nine years ago the *BMJ* allowed me to introduce to its readers an approach to medical ethics developed by the Americans Beauchamp and Childress which is based on four *prima facie* moral principles and attention to these principles' scope of application. Since then I have often been asked for a summary of this approach by doctors and other health care workers who find it helpful for organising their thoughts about medical ethics.... I have not found anyone who seriously argues that he or she cannot accept any of these *prima facie* principles or found plausible examples of concerns about health care ethics that require additional moral principles....'
(GILLON, 1994: 184, 188).

While Gillon is clearly an enthusiast for this approach, his claims (to my knowledge undisputed) in a journal such as the BMJ lead to the belief that it is widely regarded and therefore worth particular attention at this stage in my attempt at reconstruction.

## The four principles of health care ethics and health promotion

What are the four principles? The general account given here is adapted from Gillon (1994).

Following Beauchamp and Childress (1994), it is asserted that there are four key principles important to those working in the area of health care: respect for autonomy; beneficence; non- maleficence; and concern for justice. The principles are *primafacie*- each is binding, unless it conflicts with another, in which case a choice must be made between the competing principles.

A number of central claims are made on behalf of the principles. Regardless of personal background, those working in health care should find no difficulty in committing to the principles, together with a 'reflective concern about their scope of application....' (GILLON, 1994: 184). It is proposed that the principles encompass most of the moral issues arising in the field of health care. The principles cannot provide absolute answers to moral dilemmas (even if this were the purpose of ethics, which supporters of the approach might argue it is not). However they can, through providing a common moral language and set of commitments, allow the opportunity for debate and reflection. Agreement might possibly be a result of these processes.

Gillon describes each of the principles as follows:

### Respect for autonomy

Autonomy is the capacity for 'deliberated self- rule' (GILLON, 1994: 185), an attribute of individuals that in a Kantian sense renders them moral agents. The concept can be further divided into autonomy of thought (the capacity to think and

reason for oneself, hold moral views, aesthetic preferences and so on): of will (the capacity to intend to perform an action as a result of thought and reason); and of action (the capacity freely to act upon one's intentions). The principle of respect for autonomy can be described as the moral obligation to respect the autonomy of others, to the extent that this respect is compatible with the autonomy of all those actually or potentially affected by the action being considered.

**Beneficence**

This is the moral commitment to produce benefit for those with whom, or on whose behalf, interventions are undertaken.

**Non- maleficence**

The obligation 'to do no harm' is inevitably closely connected to the principle of beneficence; any intervention or action carries at least potentially the risk that it will result in harm as well as produce benefit. In order for a health care intervention to be considered as 'moral', it must always produce net benefit over harm (GILLON, 1994).

**Justice**

The principle of concern for justice can be understood as the obligation to act on the basis of fair adjudication between competing claims related to health care. Claims may relate to fair distribution of scarce resources (distributive justice): respect for natural rights (rights- based justice); and respect for morally acceptable laws (legal justice).

Each of the four principles gives rise to more detailed *de facto* obligations. For example, acceptance of the principle of beneficence would commit health care

workers, among other things, to a duty to participate in effective, continuing education and training in order that they are most likely to act in ways that will produce most benefit. Agreeing to the principle of respect for autonomy would entail commitment to a set of further obligations such as the requirement to negotiate, and to seek explicit agreement for particular courses of action with patients or clients, to provide appropriate information and so on (GOROVITZ, 1985).

A centrally important question relates to the scope of the principles; to whom do we owe the obligations they represent? Gillon (1994) suggests that for health care workers, obligations are owed to patients or clients by virtue of the special relationship they have with them. However, even this relatively broad recognition of the scope of obligations poses difficulties. For example, a doctor may feel that the principle of respect for autonomy cannot apply in the case of a patient who is under the legal age of consent and requesting the contraceptive pill. Gillon argues, though, that while there can be dispute around the question of scope (and this can sometimes be deeply felt), this does not prejudice the content of the moral obligations represented by the principles. In other words, I may disagree about to whom I owe the obligations; but it would be qualitatively much more difficult to disagree with the principles themselves.

The final point to be made in this introduction to the four principles is that while they have been applied in the context of the fields of public health and health promotion (see, for example, DUNCAN, 1995: DUNCAN AND CRIBB, 1996; GILLON, 1990a; SHICKLE AND CHADWICK, 1994; WESTRIN *et al*, 1992); they largely developed in response to the problems faced by acute medicine and health care (BEAUCHAMP AND CHILDRESS, 1994). These are the fields in which they have also mainly been applied.

This poses an interesting challenge for the bioethical enterprise as applied to health promotion. Can the four principles of health care ethics- a prominent framework for 'obligation bioethics'- be applied to the field in which I am interested? I am not suggesting here that their application in the acute medical context is unproblematic. What I am proposing is a need to test the 'fit' of principles, developed largely in another context, to health promotion activity. In order to do this, I have selected an example of health promotion work. The test will expose some of the moral problems it poses. More importantly, given a project of moral reconstruction of health promotion, it will help in assessing the extent to which the principles are of use in increasing our capacity to deal with the particular ethical problems of practice posed by the field.

**The example from practice- Helping People Change**

The example I have chosen is work on individual health behaviour change, using the so-called 'stages of change' model. Widely marketed by the Health Education Authority (HEA) through the 'Helping People Change' (HPC) training package directed at primary health care professionals; for much of the early to mid 1990s it held an important position as representative of a certain type of health promotion activity. This could be broadly described as 'lifestyle change', a class of work certainly not without its critics (ADAMS AND PINTUS, 1993) but nevertheless strongly matching and responding to what during that period was the direction of government policy and strategy (SECRETARY OF STATE FOR HEALTH, 1992). Two of my 'voices' from health promotion practice were explicitly concerned with lifestyle change work represented by HPC; Melanie and Judith, who were both considering it as activity putatively supporting the reduction of smoking during pregnancy. Lifestyle change work in a broader sense is reflected in the writing of some of my other research participants. The extent of its marketing (particularly in the

primary health care setting), together with its acceptability to those who then had political control and its frequent manifestation in practice, suggests it is a reasonable activity to review. Further, 'helping people change' (in the lower case) could be regarded as a metaphor for an important general objective of health promotion; it was a key element of the unsuccessful 'moral case' for health promotion presented in Chapter Four. In places, what follows draws upon the work of two previously published papers (DUNCAN, 1997: DUNCAN AND CRIBB, 1996) and on these occasions I will quote from the paper concerned directly.

HPC adopts the premise that those working in primary health care have the opportunity, through things like 'health checks', to help patients change 'risky' health behaviours (such as smoking, poor diet, physical inactivity and excessive drinking) (HEALTH EDUCATION AUTHORITY, 1993b). It proposes the use of a stage based model of health behaviour change (PROCHASKA AND DICLEMENTE, 1984) to determine patients' current attitude towards change. (The word 'patient' is used throughout this part of the chapter because it is almost always the term applied by primary health care workers to those using the services they provide.) The different components of this model are then linked to particular activities designed to promote willingness and capacity to change; and to maintain that change when it has taken place.

Taking the HPC training package at face value, the interventions it advocates appear to be based on identification of health risk. They aim to encourage the patient to identify and accept that risk themselves, and so alter behaviour, with relevant support at each 'stage of change'. This encouragement is only acceptable in so far as the patient's full right to self- determination is acknowledged and respected.

However, it can be quickly seen that there is the beginning of moral tension at this point:

'What is intended by the HPC interventions?.... What is most clearly intended by HPC is the encouragement of behaviour change, ultimately for health improvement. However, HPC also intends apparently to ensure decisions on behaviour change are always conceded to the patient.... Can the two separate intentions- allowing self-determination and seeking health improvement- be reconciled...?' (DUNCAN AND CRIBB, 1996: 341).

Arguably, application of the four principles may help both to expose this tension and to determine whether and how HPC might be- or become more- morally acceptable. To begin with, does the activity produce positive benefit? HPC appears to believe that patients and professionals have common cause in 'reducing the risk of unnecessary disease and premature death' (HEALTH EDUCATION AUTHORITY, 1993b: 1). But this assertion raises two questions: do HPC interventions in fact give rise to benefit?; and is it accurate to think of patients automatically allied with health professionals in the cause of protecting and improving their health?

Take the example of smoking reduction. The evidence that lifestyle change activity on smoking actually works is slender (HEALTH EDUCATION AUTHORITY, 1993a: 14). Even current work aimed at developing the so-called 'evidence base' for health promotion fails to be specific on this subject (ASHWORTH, 1997; LAWRENCE, 1999). Equally, it is not always completely correct to assert that both patients and professionals are united in their view of health and what can be done to reduce risk and to protect or improve health. It will be clear that one of the themes running through this thesis is the contestability of health, which extends from practitioners and theoreticians to 'lay' people. In relation to my example of smoking, this behaviour can in fact be seen as health risk- eliminating if it, say, protects the mental health of a single mother. Cigarettes may reduce stress, they may be the only act for self the mother is allowed and so on (BLACKBURN, 1991). Lupton (1993)

argues that the concept of 'risk' within the public health arena is impregnated with the values of those professionals applying it. Not only, then, is there little evidence of 'benefit'; but there is also difficulty in obtaining a consensus on what actually might be regarded as being of benefit. The moral case for HPC from the principle of beneficence might be weaker than originally thought.

Does HPC cause no harm and thus adhere to the principle of non- maleficence? If it is in part about risk- identification, then it could be regarded as a form of screening and subject to the well- documented charge against this activity of it having at least the potential to cause psychological harm (MARTEAU, 1989, 1990: STOATE, 1989). It has been argued that there are at least three possible sources of such harm:

'First, distress may be caused by being identified as "at risk"; second, distress may be caused as a result of behaviour change not in fact being achieved; third, distress may be caused as a result of "support" being removed during the interventions process (or alternatively not being available)....' (DUNCAN AND CRIBB, 1996: 343).

Again, then, it is questionable to believe that HPC interventions are unproblematic and will never cause no harm. Moving to the principle of respect for autonomy, to what extent does HPC adhere to this?:

'There are two main reasons why HPC interventions may not be autonomy-respecting. First.... there seems to be an assumption that patients and professionals actually or potentially share the same values, particularly those to do with health. It appears to be assumed that patients "want" the health that is being "offered" to them. Second, HPC has a highly limited view of people's actual capacity for self-determination in relation to health in "the real world"....' (DUNCAN AND CRIBB, 1996: 343).

The actual or potential dissonance between professional and patient views of, and aspirations about, health has already been noted. Given that HPC probably once was- even if it is not now- a practical expression of governmental policy and values, there is at least the chance of the policy and professional version of health dominating alternative conceptions. Further, it needs to be remembered that it is the professional who is 'in control' in the sense of knowing the full story about the cycle of change being promoted. The dominance of professional conceptions gives rise to sometimes unrealistic pictures of the levels of control patients have over their lives:

'[Adopt] a "no smoking" policy in the office so that there is less temptation to smoke when under stress.... [fill] the freezer with nutritious and convenient meals.... [fill] the fridge with cans of low alcohol beer....' (HEALTH EDUCATION AUTHORITY, 1993b: Handout C8).

While HPC may not actively set out to disrupt autonomy, its conceptions of the nature of health and the ability people have to determine what they can do to improve it lead to worries that its concern for this moral principle may be lacking. Certainly what the training pack says does not remove the worry with which this exploration began; the extent to which the supposedly mutual goals of health improvement and respect for self- determination can actually be reconciled.

Finally, the principle of concern for justice. It is probably reasonable to suggest that the notion of legal justice is not applicable to HPC. However, ideas of distributive and rights- based justice are relevant. The interventions of HPC may conflict with 'fair distribution of burdens' (WIKLER, 1978, 1987) because while they are subject to investment on the part of the state (HPC is operating with money allocated to the NHS), there is no certainty of return. It has already been argued that the intervention-benefit link in relation to HPC is far from clear, let alone causal. Thus the longer link

of intervention- benefit- economic efficiency that might be made on behalf of HPC activities fails to convince:

'It might even be argued that resources are being used to support work that in fact is relatively ineffective and may meet genuine need better if re- distributed elsewhere....' (DUNCAN AND CRIBB, 1996: 344).

HPC may also pose difficulties with regard to rights- based justice. Fundamentally, its account of health 'rights' is incoherent. It could be imagined that in promoting change to 'needy groups' (frequently of lower socio- economic status as indicators such as smoking prevalence show (INDEPENDENT INQUIRY INTO INEQUALITIES IN HEALTH, 1998)), it is re- distributing health as a right. But this argument becomes implausible when the content of HPC is considered. Its unrealistic conceptions of choice and its firm focus on individual lifestyle at the expense of a broader view of health determinants have already been encountered. Such account of health 'rights' that it gives is rendered incoherent by the overwhelming **responsibility** it casts on those to whom its interventions are directed; to choose to act in certain ways when such choice may be either beyond them or ultimately irrelevant in its effect on their health- or both. In relation to relevant conceptions of justice, then, HPC may well breach this particular principle.

At this point, the application of this version of obligation bioethics to the field of health promotion seems to be doing rather well. Assuming acceptance of the principles as representative of obligations, it has clearly allowed the identification of areas in which those involved in HPC might need to be wary, alter practice or strengthen commitment. Yet while this might be a satisfactory conclusion, it is not wholly the right one.

The essential difficulty relates partly to the nature of health promotion and partly to the nature of the principles themselves. I have just constructed an account of the deep moral ambiguity of HPC centring on the following:

* The benefits of HPC activities are far from proven; and it is also far from clear that the goods being sought will be regarded as such by all actual or potential parties to the intervention;

* Not only are the benefits of HPC work unclear: but there is also at least the possibility that it may cause harm through identification of 'risk' (which in any case is likely to be professionally constructed); through difficulties in changing behaviour to reduce such risk; and through failure to get access to adequate support for behaviour change;

* HPC may not be autonomy respecting. This is partly because of the potential for conflict over the nature of values (especially the value of health) between the different parties involved in its interventions. It may also be because HPC appears to take an over- optimistic view of the capacities people have with regard to self- determination;

* Finally, it may be difficult to accept that HPC is concerned with justice both in a distributive sense (there is little firm evidence that it will contribute to 'fair distribution of burdens'); and in the sense of justice as 'natural rights' (targeting marginalised groups with limited abilities to change does not appear to be rights-respecting).

Yet it is possible to construct an alternative account of HPC. There will be some- probably many- cases where the application of HPC interventions is both appropriate and desired. It may well be that large numbers of people do want support in reducing 'risky' health behaviour and perceive that risk is, in fact, continuing to smoke.

remaining overweight and so on (KATZ AND PEBERDY, 1997: 25). For such people, opening up opportunities to consider change is the course of action likely to promote no harm; simply not acting to raise the issues will be what is likely to encourage psychological dis- ease and harm. It is perfectly possible to imagine a sympathetic and concerned health professional raising the issues sensitively and allowing full control to the patient to determine her or his progress towards change. Although it may be rather more difficult to account for HPC in terms of encouraging 'fair distribution of burdens', the replacement of public health goals with individual aspirations (given what has just been said) might at the very least make it easier to justify activities in terms of 'natural rights'. For someone who is deeply unhappy about their smoking behaviour and who recognises its deleterious effect, HPC might help in supporting a right to health.

In my earlier critique, I assumed unequal relationships between patient and professional; and dissonance in their values. But why not accept the 'common cause of health' argument HPC supporters attempt to establish? And while it remains unclear, in terms of disease reduction outcomes, that this kind of activity actually works to any great extent; an obsession in this respect may not be helpful. It is possible to replace an arguably inappropriate yet persistent demand for 'evidence' with other more sensitive assessment criteria; acceptability to individuals and appropriateness to target groups, for example (DUNCAN, 1997).

The point is, of course, that HPC activities can be interpreted in different ways, with differing results from the kind of moral calculus that consideration of the four principles might inspire. Given that dispute and disagreement has characterised (and continues to mark) the field of health promotion in general- what I have sought to argue is a major theme emerging from my research at both conceptual and practical level- it is likely that different interpretations of the nature of work extend into many other parts of the field. Thus when the four principles are applied in an attempt to

assess the moral value of a wide range of health promotion activity, it is likely that separate conclusions will be drawn by different people.

The problem then is not just one for HPC, but for the field in general. Its emergence is partly a result of the nature of that field, but as I have indicated, it is also because of the principles themselves. They can, after all, never be anything other than general expressions of commitment, everything else being equal. Their status as *prima facie* requires that they are each binding, unless in conflict with one another in which case a choice must be made between the competing principles (GILLON, 1994). Inter-principle conflict is likely to be frequent. Even taking an uncomplicated view of HPC, this is easily evident. If, for example, it is understood as promoting the 'natural rights' of some (say, a disadvantaged group), there will be others from whom it is removing resources (such as those in need of relatively impoverished acute care following a HPC- inspired shift of finance to prevention). Health care will always face difficult choices (McCORMICK, 1990). The four principles- representatives of obligation ethics in health care- can demonstrate the difficulty of choice, but they frequently cannot resolve the difficulty or point to definitive courses of action. As I have argued, this is particularly so in the field of health promotion, because of the nature of that field.

To assert this is, of course, to do no more than would probably be acceptable to a strong advocate of the principles. Gillon, after all, argues that while they can provide:

'A common set of moral commitments, a common moral language and a common set of moral issues..... [they cannot] provide a method for choosing....' (GILLON, 1994: 184).

This is, of course, important help in any attempt at the moral reconstruction of health promotion. However, it is also important to acknowledge its limitations, emerging especially because of the nature and context of this particular field.

**Obligation ethics and 'outside in' morality**

The central problem I have identified with the application of the four principles to health promotion can be summarised as follows. The principles may simply be too broad to allow a reasonable assessment of activity, particularly in relation to a field such as health promotion, potentially filled with shades and nuances. They might do too little to support practitioner understanding and judgement. On the other hand, though, attempts to provide a more detailed set of obligations could, paradoxically do too much. They could weaken practitioner capacity for personal and professional development through moral reasoning. I will explain what I mean.

I earlier raised the idea of a 'continuum' of obligation ethics, with the four principles approach at one point on it; and such devices as codes of conduct at another. My history telling in Chapter Three gave an impression of the importance attached to the development of a code of conduct for specialist health promotion as part of the occupation's project of professionalisation. A code, and related principles of practice, finally emerged as the only tangible product of this project (SOCIETY OF HEALTH EDUCATION AND HEALTH PROMOTION SPECIALISTS, 1997b). According to the Code:

'The duties of the Health Education/ Health Promotion Specialist are based on fundamental ethical and professional principles relating to the maximisation of health....' (SOCIETY OF HEALTH EDUCATION AND HEALTH PROMOTION SPECIALISTS, 1997b: 2).

There are sixteen principles altogether, grouped around three broad areas: the practitioner's relationship to the client/ recipient of interventions; the place of social and environmental influences on health; and the nature of health promotion practice. These principles are followed by the Code itself. This sets out a number of duties and responsibilities (17 in total) incumbent on the practitioner given their commitment to the 'fundamental principles'. The Code and related principles have been supplemented by still more detailed guidance and discussion of issues in a series of 'briefing sheets', covering such topics as income generation and whistle blowing (SOCIETY OF HEALTH EDUCATION AND HEALTH PROMOTION SPECIALISTS, 1998b).

It will be clear that if the putative 'obligations continuum' is imagined as running from left (less specific obligations) to right (more specific obligations): then the four principles will be rather more to the left; and the Code (together with the principles and indeed the briefing sheets) will be rather more to the right. Does a move towards greater specificity actually give more support to any attempt at the moral reconstruction of health promotion?

Despite this enlarged attempt to map moral commitment, there is still the likelihood of conflict between both principles and articles within the Code. Take, as just one example, the following principles:

'The promotion of self esteem and autonomy among client groups/ recipients should be an underlying principles of all health promotion practice....' (SOCIETY OF HEALTH EDUCATION AND HEALTH PROMOTION SPECIALISTS, 1997b: 2).

And:

'Health promotion should encourage people to value others whatever their gender, age, race, class, religion, culture, sexuality, ability or health status, and attempt to counter prejudice and discrimination wherever it occurs....' (SOCIETY OF HEALTH EDUCATION AND HEALTH PROMOTION SPECIALISTS, 1997b: 3).

Taken at face value, there could be conflict between these two principles. Autonomy promotion, for example, could lead to a particular group failing to value another group. For example, unlimited promotion of autonomy of a group of Catholic people in Northern Ireland may lead to conflict of values with the Protestant population. Unless these two statements are to be incompatible (which is clearly not intended), then a further qualification needs to be added: something like, the promotion of autonomy to the extent that this is compatible with the equal rights of others. Once this has been done, though, there remains the problem of assessing, in particular cases, degrees of possible autonomy and their acceptability to others with the same rights.

Even with the relatively greater guidance offered by the Code and its connected principles, there is still not enough for anything other than general or provisional moral judgement. This is the defining problem of obligation ('outside in') ethics. It will be remembered that 'outside in' ethics understands the virtuous person as he or she who is aware of- and able to apply- the right moral principle when required (DAWSON, 1994). Yet while someone can accept a set of externally generated moral principles, they will never constitute enough to provide guidance in each and every situation encountered in practice. And the reliance on 'outside in' ethics- on 'knowing the right principle'- paradoxically has the effect of making intuitive moral judgement more difficult. As Edgar (1994) remarks, practice- governing rules are incomplete by themselves, their precise application and meaning governed by an infinite series of additional rules which are only understood through the member of an occupation or profession experiencing that particular 'life world' (EDGAR, 1994:

149). It is this gathering experience that is perhaps part of what might be understood by developing an 'inside out' ethics. This Aristotelian- like conception of the nature of ethics entails moving from the notion of the virtuous person as one who is capable of applying the right principle; to the one who through active development of the right disposition has the capacity and ability to act morally. Pursuit of 'outside in' ethics by those involved in the field of health promotion may have the effect of making it more difficult to develop practitioners with moral dispositions capable of dealing with individual difficult situations. The greater the degree of specificity pursued in the search for obligations, the more possible it is that the practitioner will be unable to rely on her or his own judgement. She or he may be engaged in a persistent search for the right written article or principle to meet the demands of particular practice situations; rather than make recourse to her or his intuitions.

## 4. The Futility of Bioethics?

Having completed a review of key ways in which bioethics has been applied to the field of health promotion, some provisional conclusions can be drawn. The bioethical enterprise appears helpful to health promotion because it explicitly connects the field of activity to moral values, and to dispute about values; promoting health is no longer seen as either ethically neutral or necessarily praiseworthy in a moral sense (two positions that have sometimes, as seen, been encountered in the course of this research). Moreover, some bioethicists have been concerned actually to map, describe and develop the values they believe to be important to the field. Again, this appears helpful although not without difficulty: how, for example, can the kind of view held by Downie *et al* be of use in understanding tensions between individual and societal values; and how is it possible to manage and retain a Seedhouse- like view on the nature of the value of health in the context of political and professional environments holding contrary positions? Importantly, in addition to these values- related

explorations, some involved in the bioethical enterprise have also proposed principles- based frameworks for moral commitment and deliberation (although their general nature may pose particular difficulties for moral reasoning in individual cases).

It seems, then, that the bioethical enterprise can certainly offer help in an attempt to reconstruct, in a moral sense, the field of health promotion. The enterprise's identification and discussion of values and obligations should not be ignored by those considering health promotion, although there is also a need to be aware of limitations to the understanding it provides. The view of limitations so far established has related mainly to considerations around the specific applicability of bioethics to health promotion. But there is also a need to think about broader criticisms of the bioethical enterprise *per se*. This will support a final judgement about the use of bioethics to an attempt at health promotion's moral reconstruction.

There are two particular general positions against bioethics that will be reviewed here. The first emerges from post- modernism. The second can be characterised as neo-conservative.

The first position declares itself as being committed to ethical libertarianism 'from the perspective of the post- modern condition' (ENGLEHARDT JR AND WILDES, 1994: 136). In their paper, Englehardt Jr and Wildes make a number of distinctions: between 'moral strangers' (those who do not share sufficient moral community to be able to resolve moral disagreements through rational argument); and 'moral friends' (those who do have sufficient community to enable resolution); between ' the various content- full secular moral visions.... and the canonical secular moral vision of modern moral philosophy....' (ENGLEHARDT JR AND WILDES, 1994: 136). It should be the case that the latter can be shared by all (both strangers and friends).

Englehardt Jr and Wildes offer a specific critique of the four principles approach- as representative of bioethics- from their post- modern perspective. They argue that the failure of modern moral philosophy to offer a convincing canonical vision means that the only feature of action that can define it as moral is the extent to which it allows individual consent. Thus the principle of respect for autonomy becomes 'the principle of permission' (ENGLEHARDT JR AND WILDES, 1994: 137); and the other principles- beneficence, non- maleficence and justice- are also recast so that their moral importance is credited to the extent that they contribute to individual consent.

Englehardt Jr and Wildes argue their position from two connected perspectives. The first is their assertion that the rationalist project of modern moral philosophy to unite both moral friends and moral strangers has failed (presumably evidenced by the persistence of dramatic moral disagreement); and thus the moral authority of the modern state is limited. This is confirmed from their second, post- modern, perspective which destroys the idea of the 'grand narrative' and throws up:

'The philosophical difficulty.... to identify one among.... many rival moral accounts as authoritative....' (ENGLEHARDT JR AND WILDES, 1994: 141).

Approaches such as the four principles, therefore- operating as 'middle level principles' and attempting to bind strangers and friends- cannot do so because there is no single authoritative account of morality. Thus:

'The calculations of benefits [of health care actions] will depend on different views of human dignity, responsibility and freedom. Controversies will be irresolvable unless individuals come to share a common moral vision. The appeal to the principles of health care ethics may help define and sharpen the character of the conflict. But if the individuals possess different rankings of values and different understandings of exploitation, the appeal to principles cannot lead to resolving such controversies by

disclosing hidden grounds for their resolution....' (ENGLEHARDT JR AND WILDES, 1994: 145).

It is important to note that for Englehardt Jr and Wildes, 'obligation ethics' (as represented by the four principles approach) is not a worthless project- it helps to draw out the nature of conflict. But the application of principles alone cannot resolve difficulties. Only consent- the single authoritative account of morality, both by virtue of the failure of moral philosophical rationality and of the post- modern condition- is able to do this.

It seems, then, that Englehardt Jr and Wildes' account does not completely discount the bioethical enterprise. Indeed, it is helpful in adding to the picture of its limits and possibilities. One of the struggles preoccupying me in this part of my research has been that of agreeing- even in the face of some convincing accounts- to a single version of the values important to health promotion. This in turn has led to scepticism about the possibility of moral reconstruction. Considering the difficulties for modern moral philosophy's project, from the Enlightenment onwards, of establishing rational foundations for ethics may have explanatory power for the ethics of health promotion. If there is no such foundation: and if the post- modern conception of consent being the only authoritative principle in a world of multiple traditions is accepted; why should there be a single set of values on which those involved in the field of health promotion can agree?

Further, reference to post- modern conceptions sharply yields the strong tension at the heart of the field. Foucauldian notions of the pervasiveness and complexity of power relations in the 'human sciences' might be a further way of exposing the possibility that 'empowerment' as a purpose of health promotion is a myth (DUNCAN AND CRIBB, 1996). Such an analysis is complementary to the kind of careful critique of activity that can be undertaken through the use of obligation ethics frameworks.

Foucault and post- modernism alert us to the risk of taking 'empowerment' at face value: the four principles, say, enable debate through providing a moral language likely to be reasonably understood; post- modernism again alerts us to the difficulty in accepting this is the **only** moral language. The relationship should be symbiotic.

A post- modern critique of a major direction the bioethical enterprise has taken, then, certainly does not seem to damn it completely. However, the second position against bioethics now needs to be considered. I characterised this earlier as neo- conservative. One of its key representatives is Anne Maclean.

In 'The Elimination of Morality' (1993), Maclean argues against a range of positions adopted by bioethicists such as John Harris and Peter Singer; positions on, for example, abortion and infanticide. But it is the foundation of her argument that is most interesting in terms of questioning the bioethical enterprise as a whole. Maclean begins by examining the assumption made by bioethicists (philosophers) that they possess special expertise in moral matters. What exactly conveys this expertise? It must, presumably, be an education in philosophy, for this is the one thing that distinguishes bioethicists from others. But this in turn raises the question: how does an education in philosophy convey special moral expertise?

The response of the bioethicist would be that moral judgements must be based on reason, which in turn must be subject to justification. Only philosophers are specially trained in examining assumptions. But an education in reason does not by itself allow special privilege for the particular moral judgements one makes:

'When bioethicists deliver a verdict upon the moral issues raised by medical practice, it is their own verdict they deliver and not the verdict of philosophy itself....'
(MACLEAN, 1993: 5).

This is because philosophy does not offer such verdicts. The bioethical 'technique' of using a general theory (for example, utilitarianism) to support particular moral decisions is flawed; the decision is presented as a rational one, yet the underpinning theory is not wholly or uniquely rational. Utilitarianism, say, can at best give an insight as to how on occasions some kinds of moral thinking could proceed (that is, thinking based on notions of consequence). It does not have a unique preserve- or a preserve at all- on rational justifications for moral action.

It is the apparent purpose of Maclean's argument rather than its form and content that gives it interest. In claiming that bioethicists are delivering their own personal opinions on moral matters, she is attempting to 'reclaim morality for the people':

'People in general.... know how to make moral judgements; these are judgements of a sort we are all brought up to make, and not ones for which we require a special training or education....' (MACLEAN, 1993: 188).

Of course this is an important point, paralleled in the field of health promotion by attempts such as that of Michael Kelly to 'reclaim health for the people' from the hands of 'professional health promoters' (KELLY, 1996: 24). Both Kelly and Maclean are essentially neo- conservatives. By this I mean they are against the rapid changes, the consolidation of 'professional' power and the diminution of the individual that- as they see it- are represented by health promotion (Kelly) and bioethics (Maclean). But in the case of Maclean's argument against bioethics, aside from her quite reasonable reminder of our capacity to develop moral intuition and make ethical judgements, it is not clear the enterprise is much damaged by what she says.

She is claiming that bioethicists do not have special expertise in moral matters. The difficulties I have had in reaching towards an authoritative account of the values and obligations that should be held by those engaged in the field of health promotion

provides confirmation of this. But so long as the kind of bioethical exploration I am interested in acknowledges this, it is hard to see how it should affect the worth of this sort of project. It is rather like asserting that there is no point in exploring the history of the First World War because there can be no single authoritative account. Yet it is reasonable to believe there can be a number of different accounts, each of which may provide interesting and possibly important illumination of the historical event. Equally, in the case of bioethics and its roots in moral philosophy, there are a number of interesting accounts to explore, all of which may tell us **something** about human beings and their capacity to engage in thinking with a moral purpose.

Maclean argues that general moral theory is not based on reason. Yet a broad conception of bioethics- which would include post- modern accounts as well as multiple ' grand traditions'- would not be labouring under this illusion anyway. The point is that Maclean is attacking a particular conception of bioethics; a science of precision, capable only of being undertaken by experts. This is not the conception grounding my approach to thinking about how bioethics can support the moral reconstruction of health promotion. Maclean has certainly not made a case for the futility of examining bioethics in the context of my field of interest. She has probably not made one for the futility of bioethics in general, given the broad way in which it can be conceived. Possibly she has made one for the futility of a certain kind of approach to bioethics; but this is very different to a general claim that the bioethical enterprise as a whole is pointless. (As an aside, it is interesting to wonder whether Maclean considers she is undertaking a bioethical project, and the extent to which she views her own position as that of the 'expert'.)

## 5. Conclusion

I began this chapter with the intention of determining the extent to which the bioethical enterprise could support an understanding of the moral problems of health promotion, if not their resolution. In summary, it has helped in the following ways:

* Proposing, and providing a rationale for the acceptance of, particular values (and their nature) which are argued to be important to the field;

* Proposing, and providing a framework for the consideration of, particular obligations or commitments likely to be felt important by those engaged in health promotion work;

* Recognising the disputability of morality and the sources of that dispute;

* Recognising the capacity of individuals- as well as moral philosophers- to make ethical judgements.

As discussed, the help offered by bioethics is not unproblematic. It is certainly, however, likely to be a useful contribution to an attempt at the moral reconstruction of the field of health promotion. The assertion of particular values and obligations- and limits and possibilities attached to this- has been an especially important area in which help has been received from bioethics.

Is it, however, possible to move beyond this assertion of a range of particular values and particular obligations that might be connected to health promotion and thus support justification of some of the field's activities (or alternatively alert us to worries)? Is there a sense in which the moral authority of health promotion and those who practice it can be more generally but more deeply grounded? This is the central

question of my next chapter, in which I move from the territory of bioethics (ethics **for** professions) to the overlapping one of professional ethics (the ethics **of** professions).

# CHAPTER EIGHT- RECONSTRUCTING HEALTH PROMOTION: THE IDEA OF THE 'PROFESSIONAL PLEDGE'

## 1. Introduction

While I have argued for a role for bioethics in a project attempting the moral reconstruction of health promotion, there are limits to such a role. Bioethics has proposed and discussed values that might be important to the field, but these may nevertheless still be disputed. Equally, obligations it proposes may also be argued about; and because of the nature of the field, it may be difficult to determine why, whether and how they should be pursued.

There is of course worth in disputability- debate stimulates and extends thinking at both academic and practice levels. Meanwhile, however, practitioners have to get on with health promotion activity; and their 'clients' (whoever they may be) probably have, in some way, to trust that they're doing the best they can. Individual practitioners may demonstrate their trustworthiness in countless singular ways to clients. These demonstrations might well often be accepted. If practitioners generally show trustworthiness: and if there is continued overall commitment to ethical thinking and debate with regard to health promotion (in the facilitation of which bioethics plays an essential part); isn't this sufficient? Why can't we accept the notion of 'good enough' morality?

The idea of 'good enough' morality is quite a reasonable one. However, there is a difficulty with it in the context of health promotion. As has been demonstrated, the field has consistently been (and remains) subject to political and organisational change. To many, it is also novel (even though I continue with my assertion that it actually has a long, if disrupted, tradition). Why should we trust those operating in a

novel and fluctuating field- particularly one that has at its heart a mission to change both people and structures- on the basis of 'good enough' morality? It may be possible to accept such an idea in relation to established professions such as medicine and the law, although such acceptance is still not without problems. It is certainly much more difficult to do so in relation to a newer occupation or practice.

More to the point, what seems to incline us to accept in the case of these established professions that their morality is sufficient (at least at that point where we go to seek the advice or help of a particular doctor or lawyer)? Is our trust reasonable? If in general we don't have such trust, should we have it and if so why? If there are general grounds for trusting professions, can these be applied to the field of health promotion?

As discussed in Chapter Three, attempts to 'professionalise' the occupation of specialist health promotion have been a consistent if difficult feature of its history over the last twenty years or so. The questions I want to raise at this stage of my project are:

* Can it be argued **in general** that professions possess particular moral status or value (and consequently that practitioners of professions are likely to be committed to particular, ethical, behaviour)?;

* From this, can it be suggested that health promotion **in particular** possesses (or could possess) the features that make a profession (by virtue of being a profession) ethical?

It is important to be clear about the limits to these questions and to my argument at this point. I am not trying to establish the moral case for or against professions in general through detailed empirical examination of what they do and how they are

constructed. Nor am I trying to determine whether, in an empirical sense, health promotion is- or could become- a profession. Rather I am trying to work out whether, in thinking about what a profession is (and what it is to be a professional), it could be concluded that there exist general grounds for putting moral trusting in them. Continuing from this, I am also trying to establish whether, from what we know and how we think about health promotion, it does or might possess characteristics that could allow for general grounding of trust.

This latter is, of course, quite different from attempting to establish that health promotion actually is, or could become, a profession. My project is in some respects more fundamental. If health promotion does possess grounds for trust, then this would be an essential foundation to any effort actually to professionalise. In effect, it would be possible to say that the general nature of health promotion and its practitioners is such that we can trust them. From this would be more likely to emerge a willingness (on the part of the field's consumers and controllers) to engage in the characteristic process of professionalisation:

'Individually and, in association, collectively, the professions "strike a bargain with society" in which they exchange competence and integrity against the trust of client and community, relative freedom from lay supervision and interference, protection against unqualified competition as well as substantial remuneration and higher social status....' (ERAUT, 1994: 2).

It is clear that ground for trust is a key part of the professional 'bargain'. In trying to determine the possibility and nature of such ground, a project of moral reconstruction begins to extend from professional ethics in the sense of ethics *for* professions (for example, the bioethical enterprise); into the territory of professional ethics, when understood as the ethics *of* professions.

## 2. Stating Daryl Koehn's Argument for the Ground of Professional Ethics

In considering the two questions posed above, I have been helped greatly by Daryl Koehn's influential book, 'The Ground of Professional Ethics' (1994). Her- to me- convincing account of how professions might be ethically grounded has been the basis for thinking about the first question. This account- which I generally accept although with some reservations- has been applied then to the particular context of the field of health promotion in order to try and answer the second question. Koehn's argument is complex. It is therefore important to provide a general statement of it before moving into rather more detail.

Koehn wishes to establish a ground for professional authority and moral trustworthiness, where 'ground' is understood as:

'A source of standards or norms which are binding on a certain class or group of agents....' (KOEHN, 1994: 8).

For a 'grounding' argument to be convincing, it must do the following:

(1) Specify the source of the standards governing professional activity;

(2) Demonstrate why the norms identified can be considered only to bind professionals;

(3) Legitimate therefore, in a moral sense, the relationship of trust that exists between professional and client.

In relation to (1), Koehn rejects two possible sources of moral authority- expertise and contracts- and argues instead for the **public pledge** of professionals to service and

assistance as that which grounds their legitimacy. With regard to (2), the public pledge is a declaration of intent by the professional to serve the good of her or his client- a good of which that client has need. Koehn in fact defines 'professional' in terms of the capacity to publicly pledge in this way:

'[ A professional is] An agent who *freely* makes a public promise to serve persons.... who are distinguished by a specific desire for a particular good.... and who have come into the presence of the professional with the expectation that the professional will promote that good....' (KOEHN, 1994: 59).

For (3), it is in pledging that the relationship between client and professional becomes moral. We wish our relationships with professionals to be as with those who have made promises to us. This promise- based orientation of professionals to their public may centre around explicitly made pledges; but equally it may be implicit commitments that are trust- promoting.

It is important to note that this argument for grounding will not establish that every professional relationship examined at any time will therefore be a moral one. The argument:

'Describes the *essence* of a legitimate profession.... [the claim] is not that any existent person or group fully exhibits that essence, but rather that professionals will be more legitimate the more fully they do so....' (KOEHN, 1994: 11).

Having given this bald statement of Koehn's argument, it is now possible to reflect on some of its detail.

## 3. Koehn's Argument: Some Detail- and Some Possible Objections

Against the background of pervasive and continuing critiques of professions in the last quarter of the twentieth century, Daryl Koehn embarks on a rather unusual project. Her intention is to demonstrate that professional activity rests on 'secure and morally legitimating ground....' (KOEHN, 1994: 1). Historians, sociologists, philosophers and organisational analysts have all mounted challenges against professions and their power. Yet in the final analysis we still need to trust the professions (especially the paradigmatic professions of medicine, law and the clergy) because they:

'Represent the only mechanism we have for collectively providing ourselves with the goods of health, legal justice and spiritual peace. If professionals are not trustworthy, whom should we trust?.... We cannot simply hope that the sick, the accused or injured, and the spiritually needy will provide adequately for themselves.... Given that the critics are not proposing any alternative source of help, we will be left without recourse if we cease to believe that professionals merit trust under some conditions....' (KOEHN, 1994: 5-6).

Thus Koehn begins her project of moral grounding. First, she proposes rejection of two commonly held justifications for accepting professional authority. It is often believed that professionals possess expertise which is applied to serve the good of others. The problem with this belief, Koehn argues, is that expertise creates the expert, a role which may well prove so powerful that it relegates the client to a position of secondary importance in the professional- client relationship. We may seek out professionals because of their expertise, but expertise is not a moral quality. If expertise, then, is removed from the 'expertise plus altruism' equation above, we are left only with the latter. Altruism, if it is a norm, does not only bind professionals and therefore cannot meet condition (1)- nor indeed condition (2)- for a convincing 'grounding' argument.

A second frequent justification for accepting professional authority is that we often contract for the services of a professional (an even more common phenomenon in the United States context from which Koehn is writing). Contracting entails the client paying and it is therefore incumbent on the professional to respect the client's freedom and rationality if this 'service for fee' transaction is to be a moral one.

Yet again, however, there is nothing about contracts by themselves that promote or warrant trust. Indeed, contracts tend narrowly to specify. There must always also be a question of doubt in the mind of the 'contract observer'; what is most important to the professional in the contract relationship- the client's good, or her or his money?

If neither expertise nor contracts meet the requirements of a convincing argument for the grounding of professional authority, what does? For Koehn, authority is grounded by the public pledge professionals make. They:

'Publicly pledge themselves to render assistance to those in need and as a consequence have special responsibilities or duties....' (KOEHN, 1994: 56).

These responsibilities or duties include the willingness to act: to do so in a competent way; and to exercise discretion in action according to the individual situations in which professionals find themselves. But these are all consequent duties. It is through pledging itself that the moral authority of professionals is grounded. Pledging confers ethical legitimacy not only because of the professional's commitment to service; but also because that service seeks to provide a client with a good they presently lack. A professional is:

'An agent who freely makes a public promise to serve persons (e.g. the sick) distinguished by a specific desire for a particular good (e.g. health) who have come

into the presence of the professional with the expectation that the professional will promote that good....' (KOEHN, 1994: 59).

The pledge functions as a ground for trust precisely because:

'It meets the objective requirements for a trusting relationship between professional and client....' (KOEHN, 1994: 68).

Both the client and the professional are cast as 'mutually vulnerable' in the context of the pledge. The client is in need; but the professional is also potentially in need because she or he has committed to help even at personal cost.

At this stage, two difficulties with Koehn's argument should be noted. The first is descriptive; the second ideological. The descriptive problem is this. Pledging is not just a feature of professional activity. In both our occupational and our personal lives, we frequently make pledges (moral commitments) to each other. My plumber pledges to fix my central heating: the couple getting married pledge to be faithful to each other.

Asserting this does not damage Koehn's argument in a fundamental sense. The pledge still 'meets the objective requirements for a trusting relationship between professional and client.' But if pledging is a common experience, then it becomes part of 'ordinary' morality and 'ordinary' moral relationships. It could, of course, be argued that there is a special moral position attached to professional pledging by virtue of what is being pledged (a good central to human well- being such as health or liberty, say); and the social context in which the pledge is being made. But there is a risk in this argument. Why should, for example, the good of health have greater moral importance than the good of faithfulness or even- in some particular circumstances- the good of warmth? Simply asserting a special moral position for pledging related to a particular good,

without accompanying reasons, is likely to present difficulties. It is less problematic to agree that pledging may be the ground for a relationship that could lead to particularly important and needed goods, subject to the relationship assuming the responsibilities or duties consequent on pledging. Within the complex of pledging, consequent duties and needed goods, it may be possible to assert a special moral position for the professional who pledges.

It is now possible to move to the second, ideological, problem with Koehn's argument up to this point. According to her, pledging allows, among other things, for professional discretion and self- responsibility. But doesn't conceiving of pledging in this sort of way simply return us to arguments against the power of professions constructed by sociologists, historians and others- the very arguments which prompted this attempt by Koehn to try and morally ground professional authority?

Koehn's counter- argument to this would presumably refer back to the basis of pledging: the public pledge to people distinguished by the need for a particular (lacking) good. It would be difficult to imagine, say, discretion employed for the self-interest of the professional emerging from this conception of the ground of professional ethics. But there remains a problem. Pledging is sufficiently vague to allow different interpretations as to the acceptable limits of action for the client's good. And here is where it becomes essential that the pledge does not stand alone *qua* ethical professional practice- but rather as the ground of relationships and more detailed duties, all of which should be submitted to moral examination. (To be fair to Koehn, her concern, throughout 'The Ground of Professional Ethics', to describe her own conceptions of limits to discretion and the nature of goods being sought by public and professionals suggests she also wishes to become clearer about the more complex picture.)

This brings us back to Koehn's original purpose. Given that the critics of professions are offering nothing to take their place: and given the goods they provide are arguably fundamental; grounding the moral authority of professionals is an essential task. We need them, we need to trust them and in some way that trust must be grounded. If moral grounding is the identification of a source of standards or norms binding on a certain group, then in a general sense this has been accomplished. Professionals, because they are professionals, freely pledge to serve the public good and particularly those individuals in need of specific goods.

But Koehn would want to claim that the ground of the public pledge is only *prima facie* indication of professional trustworthiness. Further, general trustworthiness does not indicate morality in specific cases. As I have made clear, more detailed work needs to be carried out in order to determine this. Nevertheless, a ground for general trust in professionals has now been determined. The question at this point is whether such a ground applies- or could apply- to health promotion.

## 4. Can the Idea of the Public Pledge be Applied to Health Promotion?

Pledging, then, is *prima facie* an expression of interest in the professional being perceived as moral; and a declaration of her or his moral intent. Following Koehn, I argue that 'moral pledging', as the ground of professional ethics, is dependent on two necessary conditions being met. First, that there is a client need for the particular good the profession concerned has the capacity to supply or meet. Second, that the profession in general commits itself to helping those who have need of that good. If these conditions are met, then pledging will be a ground of the moral authority of the profession. Does health promotion meet these conditions? (It is crucial to remember here my important initial remark that I am not trying to establish the validity, in an empirical sense, of the claim that health promotion is- or could be- a profession. I am

trying to work out whether the idea of pledging could be applied to health promotion. thus indicating the *prima facie* trustworthiness of the field.)

Before addressing this question, some preliminary remarks are required. First, I recall the distinction made throughout this work between, on the one hand, health promotion specialists; and on the other, health promoters. Health promotion specialists are those who have the promotion of health as their main or exclusive occupational role. This is the group whose history of attempts to professionalise was charted in Chapter Three. Health promoters are those who have the promotion of health as part of their occupational role- for example, nurses. Frequently, health promoters have been encouraged to develop competence in respect of health promotion; in other words, to undertake professional development related to the promotion of health. They have not, however, participated in a project of professionalisation, of trying to become the profession of specialist health promotion.

It could be argued here that nurses, for example, constitute the profession of health promotion; that the nursing role is, *par excellence*, about health promotion. This in fact starts to bring out a major difficulty in attempting publicly to pledge the promotion of health which will be discussed later in this chapter. For the time being, I assert that those involved in nursing pledge 'to nurse' (which may- indeed should- include the promotion of health). Those involved in specialist health promotion presumably pledge to 'promote health' (that is to say, it is their primary, and possibly only, pledge).

The second preliminary remark is to suggest from empirical evidence that 'pledging' appears to assume some significance in the field of health promotion. Documents such as the Ottawa Charter for Health Promotion (WORLD HEALTH ORGANISATION, 1986) and the Adelaide Recommendations on Healthy Public Policy (WORLD HEALTH ORGANISATION, 1988) seem to be full of 'pledges'.

Take this example from the latter document, discussing healthy public policy (which is understood as a component of health promotion):

'Healthy Public Policy is characterised by an explicit concern for health in equity in all areas of policy and by an accountability for health impact. The main aim of Healthy Public Policy is to create a supportive environment to enable people to lead healthy lives. Such a policy makes healthy choices possible or easier for citizens....' (WORLD HEALTH ORGANISATION, 1988).

However, this empirical evidence of pledging- like statements in the field of health promotion does not answer the question of whether the two necessary conditions for 'moral pledging' (client need and profession commitment to helping those with such need) are likely to be met by the field.

The third and final preliminary remark is that in the rest of this section, I most frequently refer to the 'clients' of health promotion. This is not because I believe this to be the most applicable term. It is simply because it is the one most used by Koehn herself.

**Do clients need the good of health, as supplied through health promotion?**

The arguments I presented in Chapter Seven made it clear that 'health' was a good, or value. Arguably, there is a need for more of this good, a need expressed in part through public policy and strategy (SECRETARY OF STATE FOR HEALTH, 1992, 1998; DEPARTMENT OF HEALTH, 1998). Surely, then, health promotion meets the first necessary condition- of client need- for 'moral public pledging'?

Throughout previous chapters of this thesis, I have argued for the disputability of the concept of health. I have cited examples of the rich variety in lay interpretations of

health (such as CORNWELL, 1984: HERZLICH, 1973). I have also discussed difficulties experienced by theorists in reaching agreement on a unified perspective (for example, DOWNIE, TANNAHILL AND TANNAHILL, 1996: HARE, 1986; SEEDHOUSE, 1986; SCADDING, 1988). There is thus at the very least the possibility that perceptions of the need which the client has may be very different depending on whose point of view is being taken.

Compare the field of health promotion with that of the paradigmatic liberal profession of law. The lawyer defending a client on a charge of robbery is concerned to serve the client's best interests in the face of this legal charge. The lawyer has pledged herself or himself to:

'Render assistance to those in need and as a consequence [has] special responsibilities or duties....' (KOEHN, 1994: 56).

The needed good is clear (representation in the face of the charge) and so, therefore, are the duties and responsibilities required. They would include the requirement for the lawyer to turn up in court on behalf of the client, to present or arrange the defence, to interpret the law for the benefit of the client's understanding and so on.

This clarity about needed good and consequent duties and responsibilities is at least sometimes not shared by health promotion activity. As a professional engaged in such activity, I may see stopping smoking as an important way of acquiring the needed good of health. However, there will be at least some occasions when my clients do not share this view. There will be disagreement about the need and therefore about my duties and responsibilities. I may see it as my responsibility to provide advice to the client about quitting smoking, but the client does not want such advice. Admittedly, legal clients also sometimes reject advice from their lawyers. But this is not usually because they see no need for the good of legal representation. (Having

rejected advice, they assume their own defence, or less dramatically engage alternative counsel.) If a client rejects smoking advice, it is likely to be because he or she does not see the need for the good being offered. In this sort of case, by virtue of the nature of 'pledging', pledging to promote someone's health through helping them to stop smoking cannot be a pledge at all.

But isn't this example very specific and isn't it very often true that health promotion practitioners and clients agree on what constitutes good? This could certainly be the case, although I would argue that instances where agreement is lacking or not explicit are quite commonplace in the field of activity. In any event, even if there were just a small number of cases in which disagreement about the needed good existed (and I think there is actually quite a large number); this would show pledging for health promotion to be only a relative possibility. 'Relative pledging' is not pledging at all, at least in the terms established by Koehn. The person promoting health cannot freely make a public promise to serve individuals distinguished by a specific desire or need for that particular good (health) because its nature is disputed.

It might be argued that pledging could be made applicable to health promotion by trying to frame a more general pledge that takes account of difficulties engendered by the nature of the needed good of health being disputable. This would involve, say, a general agreement on the good of health and action to promote it being subject to negotiation and review between the practitioner and the client. If those involved in health promotion activity took such a general pledge seriously, then in specific cases there would always be certainty- through agreement and negotiation- that the client was in fact distinguished by a specific desire for a particular needed good. Arguably, this might not be that different from a model for action entailed by Koehn's conception of pledging and the paradigmatic liberal professions. A lawyer or a doctor, for example, would presumably want to substantiate their general pledge with more

detailed consultation with clients about what in this specific instance was actually needed or wanted.

Here, though, considerations of context become important. For Koehn, the public pledge is the ground of trust between client and professional. It underpins a series of more detailed moral commitments associated with a specific relationship: orientation to action; commitment to assistance offered being ongoing; appropriate degrees of professional discretion; and the relationship cast in 'mutual vulnerability' (KOEHN, 1994: 68). Yet for some involved in the field of health promotion- namely, health promotion specialists- this specific relationship frequently does not exist. As I have described, this occupational group is often once removed from lay- clients. Its members are pre-occupied with such things as developing policy or supporting health promoters. For these, any general pledge cannot be connected to the moral detail required by a particular relationship. Thus, a general pledge remains just that- general. Imagine a statement based on the idea of the general pledge for health promotion described earlier:

'Broadly, we agree that health is a good thing. Subject to that agreement being confirmed by all parties, and the agreement being reviewed at regular intervals, we will do all we can to promote health....'

At best, this can only be a statement of overall moral intent. It is certainly not a public promise to serve those distinguished by a specific desire for a particular good, the *prima facie* ground for trust in professionals. The difficulty is that the nature of the occupation of health promotion specialist does not allow for the general statement to be supplanted by a more particular pledge.

Arguably health promoters, by contrast, do have the kind of client- professional relationship that would allow for the more detailed moral features described by

Koehn. Could pledging ground the relationship between health promoters and their clients? Take practice nursing as an example of an occupational role with, at least in part, a health promotion function. The role is oriented to action: it is likely to involve ongoing relationships with clients, quite possibly with the promotion of health as their purpose (for example, ongoing counselling, advice and support for someone who wants to give up smoking): and a practice nurse may operate with degrees of professional discretion. In this context, is the idea of pledging any more reasonable?

Imagine Sue, a practice nurse and Mrs Smith, a patient. Sue has met and helped Mrs Smith on several previous occasions and knows she is concerned about her health. (Mrs Smith was recalled to cervical screening two years ago, is rather overweight and has made at least three attempts in the past to quit her 20 per day smoking habit.) After a gap of several months since her last visit, Mrs Smith appears at the surgery again. She walks into the practice nurse's office and after a few preliminaries, Sue declares, 'I will do what I can to promote your health, Mrs Smith.' Such a statement might seem more than a little odd. Yet would oddness have been similarly felt if Sue had said, 'I will do what I can to help you'; or even, 'I will do what I can to look after you.' ?

Feelings of oddness or otherwise in relation to these scenarios demonstrate that in the relationship between Sue and Mrs Smith, it is not the practice nurse's pledge to promote her health that is either the most important or the most appropriate. It is what I have crudely referred to already as the 'nursing pledge'. Centrally, this is a pledge to **nurse**. If the pledge is unpacked a little, it would include components of the nursing role such as caring and advocacy. It would also include the promotion of health but at best this would only constitute a part of the nursing pledge. I argue that the promotion of health might equally form part of the pledge of other occupational groups (for example, teachers) but again it is- and can only be- one component.

In thinking again about the example of nursing, there is at least the possibility that someone could reasonably believe nursing in fact to be health promotion. Macleod Clark (1993) has presented the case for regarding the fundamental role of nursing as 'health nursing' (that is to say, the nurse's *raison d'etre* is the promotion of health and would become his or her primary ' profession', or pledge). The context of nursing (particular relationships between clients and professionals) would thus allow the first necessary condition of trust grounding- client need of a specific good- to be fulfilled by an important occupational group. Nurses (first and foremost health promoters) pledge to nurse (that is to say, to promote health); and their relationships with individual clients (patients) allow- at least in respect of this condition- that *prima facie* grounding is the basis for the more detailed establishment of trust in particular cases.

But this position is deeply problematic. Common sense tells us that people most often seek the help of nurses because they desire the particular good of being cared for while they are ill- or perhaps even when they are dying. While theorists might want nursing to be 'health nursing'; for the great majority of people, it is 'sick nursing' (that is to say, nursing the sick). The preoccupation of 'sick nursing' with health promotion is mainly of a particular kind. This can be understood as rehabilitation or restoration of health in those who are ill or diseased (or help to a peaceful death in the case of the dying). At best, prevention and positive health promotion are only add- ons to this role and may not be regarded as related to it at all. Throughout this thesis, beginning in the first chapter, health promotion has been conceptualised by most of the different voices to whom I have been listening as more like the latter (that is to say, prevention and positive health promotion). There are thus two different conceptualisations of 'health promotion': the one held by most of my voices from theory and practice; and the other that identified as the preoccupation of 'sick nursing'.

This is where the problematic lies. The public perception of nursing as I have suggested is overwhelmingly one of 'sick nursing', with a very different story to tell about 'health promotion' than that which has dominated this thesis. If we wish to claim that the needed good supplied by ' sick nursing' is 'health promotion', we have to do one of two things. First, we would need to spend substantial time making it explicitly clear that the things most usually associated with 'sick nursing' (caring for ill people and so on) are in fact what ought generally to be regarded as 'health promotion'. If we do this, then we ignore a widespread view from academics, practice (and probably the broader public as well) about what 'health promotion' actually is (prevention and the promotion of positive health). Alternatively, second, we continue with the implicit, unexpressed assumption that what many people consider to be 'health promotion' is not such at all and that the version supplied by 'sick nursing' (caring and so forth) is the authentic one. The deep difficulty with both these positions in terms of pledging as a ground for trust is that neither seems honest. Both fail to acknowledge important conceptions of, on the one hand, 'sick nursing'; and, on the other, 'health promotion'. We would essentially be pledging in the knowledge that there were competing views about the nature of the good being pledged. (It doesn't work here to suggest that both versions of 'health promotion' can live side by side. Remember the claim being made is that nursing (for which necessarily read 'sick nursing') is pledging 'health promotion'; as I have argued, 'sick nursing' is strongly associated with a particular set of activities that bear little relationship to other conceptions of 'health promotion'.)

I have chosen nursing as the main example within this section because it appeared to be the occupation with the greatest potential to fulfil this necessary condition of pledging with regard to health promotion. It seems to me that other occupations- for example, teaching- face even greater difficulties in this respect. There is no model of 'health teaching'. Of course, there are those who teach abut health, but this is not the same thing. And the idea of teachers who ' teach in a health promoting way' faces the

same problems as the nursing example above, although without the benefit of a coherent theoretical model.

**Is there a professional group commitment to helping those who have need for the particular good of health, as supplied through health promotion?**

It will be clear, then, that health promotion fails to meet the first necessary condition- that of needed good- for pledging as a ground for trust. This is because both of the disputed nature of the good; and the contexts in which pledging might actually or potentially occur. If this necessary condition cannot be met, then health promotion- at least as far as pledging goes- cannot have its moral authority grounded. However, it is possible to imagine that if certain extra conditions were fulfilled- acknowledgement of the disputability of the good and much greater public development of the idea of 'health nursing' for example- then sometimes, in some cases, the notion of 'pledging health promotion' might be less remote than it seems to be at present. Given the purpose in this part of my thesis is to examine how health promotion might be reconstructed in a moral sense, it is important to consider this as a possibility. Despite present failure to meet the first necessary condition, it is thus also important to consider how the field might fare in relation to the second condition- professional group commitment to helping those who have the need for the particular good of health as supplied through health promotion.

I return again to the distinction between health promotion specialists (at least some of whom are attempting to professionalise this occupation); and health promoters (many of whom are being encouraged to engage in health promotion- related professional development). Those in this latter category are drawn from a number of different occupational groups. In an empirical sense then, even at this early stage of consideration it looks unlikely that a 'unified professional group commitment' to meeting the need for the good of health, as supplied through health promotion, can

exist. The simple problem is that 'health promotion', at this stage of the enquiry, is understood mainly as a field of activity undertaken by separate occupational groups (although sometimes- possibly frequently- working together). Moreover, individuals within these occupational groups are likely to have different conceptions of the relative importance of health promotion to their work. (It is not unreasonable to suggest that not all nurses or all teachers, say, are uniformly committed to promoting health.)

There is, however, one occupational group in which all its members should share a relatively equal commitment to health promotion. This is the group of health promotion specialists. (Arguably, they come closest to connecting the different senses of 'health promotion' it might be possible to employ here- as occupation, as field of activity and as practice.) There is, however, a paradox to unfold at this point. A detailed story was told in Chapter Three of attempts by at least some of this occupational group to professionalise; to take on the values and attributes of a profession in order that they also would become members of a 'new' profession of specialist health promotion (HOYLE, 1980: ERAUT, 1994). Attributes the professionalisers tried to develop included formalised training on which licence to practice was contingent, a code of conduct and so forth. Such things are likely to place ideological and practical ground between the occupational group of health promotion specialists; and the larger body of health promoters. Paradoxically, professionalisation renders more difficult the possibility of a unified professional group commitment from those in the field of health promotion to helping people with need for the good of health. Although possibly unwitting and probably undesired, this is certainly likely to be a consequence of professionalising specialist health promotion.

There are further problems to be faced here. Health promotion specialists are reputed to be collaborators (RAWSON AND GRIGG, 1988: SOCIETY OF HEALTH

EDUCATION AND HEALTH PROMOTION SPECIALISTS, 1997a, 1997c). If a putative pledge from this occupational group was to be framed, it would almost certainly have as a central feature the requirement for collaboration in the cause of health.

Yet professionalisation is likely to stifle collaboration. This is because it will put ground between specialists and health promoters. It will also do this because- despite the importance of the relationship between the specialist occupation and health promoters- the latter can have no active part in the project. If they did, the project would cease to be one of professionalisation because processes would no longer be confined to, and under the control of, one distinct occupational group. It is therefore at least possible that the end results of professionalisation will not be acceptable to (certainly they will not have been agreed by) health promoters. This will affect the idea of 'common cause' between specialists and health promoters, likely, I have argued to be a central feature of a specialist occupational pledge. If health promotion specialists continue to professionalise, they lose an important feature of their putative pledge. If they abandon this project, their distinctiveness from other occupational groups- and hence of any possible pledge- is lost.

## 5. Conclusion

It appears, then, that there is difficulty with those involved in the field in which I am interested meeting the second necessary condition of moral public pledging- professional group commitment to helping those who have need for the good of health, as supplied through health promotion. This is partly because multiple occupational groups are engaged in the field of activity, making unified pledging certainly very difficult and probably impossible. It is also because the one occupational group whose members are likely to possess relatively equal commitment

to the promotion of health- health promotion specialists- have engaged in a project of professionalisation. This has moved them away from other groups and renders them less able to fulfil what ought to be an essential component of their role, most probably as well as a major feature of any pledge they might want to make- the capacity to collaborate.

Once again, however, although there are difficulties in the field of health promotion at present in meeting this necessary condition for grounding trust; some putative features of a more solidly grounded field have been uncovered. These include the need to examine the extent to which there is or might be, in fact, inter- occupational agreement on the worth of health promotion in helping those who have need of the particular good of health. It might also include the requirement for those engaged in the professionalisation of specialist health promotion to consider the impact of their vision and ideology on a central principle of the work to which they are committed; and how ignoring this might reduce the possibility of 'common cause' in the field.

Koehn's account of pledging as the ground of professional moral authority cannot at present, then, apply to the field of health promotion. This conclusion is independent of any thought about the actual empirical state of affairs with regard to the field being perceived (or otherwise) as 'a profession'. However, her account has enabled identification of exactly why 'pledging health promotion' is at present difficult, if not impossible. In summary, this is because:

* Health is a disputed value;

* The particular context of many 'health promotion relationships' makes detailed pledging highly problematic;

* The inter- occupational nature of work that could be considered to be 'health promotion' prevents or makes difficult a unified voice;

* Professionalisation also poses a risk to health promotion unity.

These are valuable conclusions. Together with views already gathered in the previous chapter on the limits and possibilities of help available to health promotion from bioethics; they will be used in the final chapter of this thesis where- with the help of my research participants- I attempt to make a contribution towards the moral reconstruction of the field of health promotion.

# CHAPTER NINE- TOWARDS HEALTH PROMOTION'S MORAL RECONSTRUCTION: REFLECTING ON THEORY AND PRACTICE

## 1. Introduction

In this final chapter, I draw together the strands of my thesis. When I began this work, it was with the view- based mainly at that point on intuitive feeling- that health promotion as theory and practice contained substantial moral problems. However, my intuition went little further than a general sense of ethical unease. If my view was to be substantiated, I needed rigorously to investigate the development and present nature of health promotion as theory and practice.

Thus I began to listen to, and try to understand, a number of 'voices' providing perspectives on health promotion. I listened to the voices of key theorists describing their typologies of health promotion. On the assumption that historical analysis can help in understanding present problems, I sought the descriptions and interpretations of historians, both of health promotion in particular; and of the general social and cultural context in which it has developed over recent times. I returned to theorists in order to understand how they would be likely to construct a moral defence of health promotion; then sought critically to examine such a defence.

To inform my views- and to gain a richer insight into the nature of problems- I got the help of a number of practitioners. With problems of theory and practice exposed, I then began to seek help as to how health promotion might be reconstructed in a moral sense: first from bioethics; then from broader theoretical understanding on the nature of professional ethics.

Now my task is to draw together these strands of theoretical critique and help- and of illuminating practitioner perception- in order to determine what might need to be done in order to move towards the moral reconstruction of health promotion.

## 2. The Value of Moral Theory in Exploring the Ethical Problems of Health Promotion

After establishing that health promotion faces major moral problems, I sought help from moral theory to see how they could be understood and dealt with. This process was described and discussed particularly in Chapter Seven. While acknowledging some limitations in the assistance that could be found from theory; nevertheless there were important ways, I argued, in which it could support the understanding and management of moral problems in health promotion. My research participants- the student- practitioners whose academic writing I analysed- underwent a similar process of learning and understanding through the consideration of ethical theory. My intention now is to examine and reflect on this process.

It will be remembered that my participants had been required to:

'Demonstrate an understanding of.... the ethical and philosophical considerations [ of the health promotion programme being discussed]....' (SOUTH BANK UNIVERSITY, 1995b: 16; 1996b: 17).

It is, though, important to explore **how** these practitioners used moral theory and what they felt its effect to be. While I have argued for value in aspects of the application of moral philosophy (particularly bioethics) to health promotion; it is necessary to ask whether this sense of value might be confirmed by practitioners.

My participants sought help in the main from moral theories of obligation. There was relatively little reference to Aristotelian conceptions of morality as being about attempting to determine the nature of the good or valuable life. The nature of the moral theory to which participants mostly turned reflects the content of the unit's teaching (focused on obligation ethics and frameworks for moral obligation); which in turn is a reflection of the dominant Anglo Saxon moral philosophical tradition, at least over recent history.

There was wide use by the participants of frameworks for establishing moral obligation; products, as discussed in Chapter Seven, of the bioethical enterprise. Of my 17 participants, 13 made use of the four principles framework of Beauchamp and Childress (1994), or as adapted by Gillon (1990b: 1994). Three writers referred to, or used, Seedhouse's 'Ethical Grid' (1988). Three writers also used a framework I developed myself which makes reference to the four principles and emphasises the need for knowledge about an activity's aim, approach and effectiveness as moral calculus is being undertaken (DUNCAN, 1995). (These numbers exceed 17 because some writers used more than one framework. For example, Tim- who was writing about the activities of the Christian voluntary group concerned with female sex industry workers- used both Seedhouse (1988) and Duncan (1995).)

Only two of the writers made little or no reference to obligations- based frameworks for moral reasoning. These were Patricia, who was considering health promotion epistemology, needs assessment and general practice; and Donna, who was reflecting on politics, local government and health promotion. It is possible to offer reasons for this and I will return to their writing later.

While frameworks were employed extensively in general by the writers, exactly how they were used varied between individuals. Some, for example, chose to lay out frameworks of principles in a formal way; and to use a number of principles as the

basis for listing and discussing points 'for and against' the activity they were writing about. Frameworks thus took on the appearance of an aid to moral calculus. Iris, it will be remembered, is writing about water fluoridation:

*'Does fluoridation compromise autonomy?....*

*'B..... Health Authority .... accepts that fluoridation would be ideal, i.e. accepting its beneficence, non- maleficence and the fact that it impinges on autonomy, but rejects it on grounds of cost....'* (Iris).

She concludes:

*'Thus in the case of fluoridation, the benefits, beneficence and non - maleficence outweigh any impingement on autonomy....'* (Iris).

Others chose to concentrate on one particular principle within a wider framework to support or reject arguments for an activity. Discussed most frequently and at greatest length was the principle of respect for autonomy. Generally, writers took the view that adherence to this particular principle confirmed the morality of an activity (and its breach suggested at the least an ethical dubiousness). John, however, was slightly more circumspect and doubtful about the relationship between autonomy disruption and the ethics of an intervention:

*'Not being able to smoke in schools by the over 16s would only appear to infringe personal liberty (autonomy) but looking at the issues I have put forward it is certainly a benefit for the majority. After all, people are not being stopped from smoking, only restricted in where they can for the comfort and safety of all....'* (John).

David, writing about Tackling Drugs Together, represents the characteristic view of the fundamental importance of the principle of respect for autonomy:

*'[The strategy] places strong emphasis on control, it promotes understanding of a particular and limited type and it attempts to ameliorate certain specific aspects of intentionality. It seems clear.... that [the strategy] has no respect for autonomy....'* (David).

Judith, discussing smoking prevention interventions during pregnancy, is equally explicit about the importance of the principle:

*'As a rational moral agent, the woman's freedom to do as she wishes with her own body should be paramount.....'* (Judith).

Mandy, writing about the primary schools self- esteem project, extends her thinking beyond simply respect for autonomy and argues for autonomy **creation** as the crucial task for schools health promotion:

*'What is our potential for the development of autonomy?*
*'How can we foster autonomy?*
*'Whose responsibility is it? State, family, church, self?*
*'What does autonomy mean for young people?*
*'How can we recognise that someone has acquired or is developing their capacity for autonomy....?'* (Mandy).

The writers tended to use the frameworks as tools for ethical deliberation and decision- making without providing a critical perspective on the frameworks themselves. Moira, writing about nurses' understanding of 'autonomy', demonstrates her view that frameworks are required instruments for moral decision- making:

*'However our decisions* [about the morality of particular health care interventions] *are obviously based on personal value judgements which raise the issue of bias and therefore the need for a framework, e.g. the 4 principles approach and the ethical grid.....'* (Moira).

In noting that the writers did not provide a critical perspective on the frameworks themselves, I am simply remarking on this fact. It is hard reasonably to expect that they should have done so. This was a group of practitioners perplexed by moral problems in their work and seeking help through theoretical understanding. That they used, and appeared to find support in, theoretical frameworks is a sufficiently important outcome- let alone expecting sustained appraisal of the frameworks themselves.

The frameworks of obligation discussed, together with the moral theory from which they are derived, are largely secular. Most of my participants wrote with no reference to religious tradition. However, Tim, writing about the Christian voluntary group working with female sex industry workers, was concerned to identify himself early on in his writing as a Christian. He connected deontological and consequentialist obligation theory to Christian ethics:

*'Essentially, the methods and procedures of Christian ethics appear to straddle the two theories* [of deontology and consequentialism] *and are no different from those of moral philosophy, other than its starting point in the Christian faith...'* (Tim).

Two of the reports did not draw on moral theory- particularly frameworks of obligation- in any substantial way. This can be related largely to their separate focuses. Patricia was writing about epistemological issues emerging from general practice health promotion needs assessment. Her work was therefore at one remove

from considering the ethics of particular interventions or kinds of interventions. Donna was writing about broad issues related to the politics of health promotion in local authorities, again without specific reference to particular activity. In both cases, the absence of a specific 'activity focus' was likely to have made the use of any framework of obligation less applicable.

The quotations above from the writing of Iris, David and Judith suggest that frameworks have supported judgement. Iris has come to the conclusion that the likelihood of benefit being produced by water fluoridation makes it an acceptable intervention despite the risk that this population intervention may not respect the autonomy of individuals or particular communities. David has recognised that the limited perceptions of 'health' contained in Tackling Drugs Together is likely to mean that it will cause problems in terms of respect for individual autonomy. Judith has identified the central importance of freedom of choice as women make up their minds about smoking during pregnancy.

Anthony provides a further demonstration of obligations- based frameworks supporting decision- making. His implicit questioning of the value of anti- HIV combination therapy- related in part to the uncertainty of its action and effect- was evident at the end of Chapter Six:

*'Even within an orthodox western medical model the optimum time to start treatment with anti- HIV drugs is open to debate....'* (Anthony).

He then introduces and considers the framework offered by Beauchamp and Childress and later writes:

*'For Gary with dementia, I value the role of Zidovudine as it reverses such symptoms and restores autonomy.... For Clare whose children are not yet autonomous adults, I*

*value the potential of anti- HIV drugs for securing a longer life but I also respect her autonomy....'* (Anthony).

Of course, the empirical uncertainties related to anti- HIV drugs remain. However, Anthony now has a clear framework within which to engage in moral deliberation about the potential value of particular courses of action. His enhanced feeling of being able to identify the moral nature of his actions and those of his clients is replicated in the writing of my other participants. This apparent usefulness of frameworks of obligations to this group of practitioners supports some of the claims I made earlier on (in Chapter Seven) for the worth of bioethics applied to health promotion: that it can provide a rationale for the acceptance of particular values likely to be important to the field; and that it can provide frameworks for considering obligations, commitments and courses of action.

What has happened in the cases of Iris, David, Judith and Anthony? Certainly, there has been a change in knowledge on their parts. They now have greater knowledge of moral philosophical principles and frameworks for decision- making that might be agreed on by those engaged in health care activity. But it seems clear that something else has happened as well. Accompanying altered levels of knowledge is a change in **attitude**. Anthony, for example, demonstrates doubt and confusion about his role in encouraging the use of anti- HIV drugs at the beginning of his assignment. Yet he concludes with a clearer perception of both the value of such drugs in some cases; and the value of the lives with which he is involved. (This is not to suggest that he failed to value those lives beforehand- simply that his perceptions of, and attitudes towards, those valuable lives has altered.)

One of the most marked attitudinal changes was that of Alison, who was writing about the introduction of a no- smoking policy at her college of further education. As I have already described, her views towards the policy shifted from one of tacit

agreement and support to one of suspicion, doubt and even opposition. She had uncovered alternative, 'non- health' motives lying behind its introduction:

*'My life now is divided up in to two distinct parts- before Philosophy and after Philosophy. If I had to analyse the* [smoking] *policy in the "Before" part, I would not have been able to justify my argument, as my views and ideas would have been cloudy and unclear. Having followed the sessions on Philosophy (backed up with further reading), I feel that my views and ideas have changed, but more importantly clear justification for them can be given, and my thinking has become more formalised as I have been introduced to different frameworks and tools to work with....'* (Alison).

Here Alison is expressing the view that related to an increase in knowledge is a change in attitude. This is expressed in part through the simple change in attitude towards the smoking policy; but also through the greater confidence she has in the justifiability of her view as a result of greater knowledge. The relationship between changes in knowledge and alterations in attitude is symbiotic.

Alison's change in attitude is striking and clear. Judith writes rather more diffidently about alterations in her attitude towards work on smoking prevention with pregnant women:

*'I have to accept that I feel ambiguous about the issue and allow myself the space to discuss some of the concerns with colleagues. Although ethical issues have been raised, I would still undertake the training but at the same time try to influence those decision makers that we should not be solely concerned with the statistics of how many pregnant women stop smoking.... '* (Judith).

Of course, a gap may exist between attitude change and alterations in behaviour related to this. For David, writing about Tackling Drugs Together, his change in

attitude included a mood of cynicism, anticipated before he began the assignment but even more acutely felt as he analysed the ambiguities contained in the strategy and work to implement it. Here was an apparently unassailable central government policy document, given legitimation through cross- political party support; and fed in turn by public and media opinion. Politicians, media and much of the public had 'black and white' views on drugs misuse. He writes:

*'Certainly it has been useful to take the time to consider in depth some of the many issues raised....* [But] *there was a clearly stated risk for the author at the outset. The risk was that deconstruction of Tackling Drugs Together would leave it naked and exposed to criticisms of futility. When one is deeply engaged at a strategic level in attempting to make such an initiative work, this needs to be underpinned by some feeling that, at the very least, more good than harm is likely to result from the activity....'* (David).

While recognising there may be some benefits in working according to the Tackling Drugs Together strategy, he goes on to remark:

*'A more radical approach* [than that implied by the strategy] , *particularly one that used the starting point of social and economic realities underlying drug use, is simply not on the political agenda currently....'* (David).

David exemplifies the views of a number of the writers that the activities in which they were involved were non- negotiable as far as those with political or organisational control of health promotion work were concerned. For others, however, change in knowledge and attitude might just hold the potential for practice alteration. Carol reflects on the young women and sexual health community project with which she was involved:

*'I believe a way has to be found to evaluate and value the process of chosen interventions that satisfies the entrenched positions of those in power. This does not have to be at the expense of the intuitive and innovative methodology that I believe is the bedrock of a profession that values people....*

*'How to do this is beyond the scope of this critical report but will be the beginning of the next. The seeds of inquiry have been sown....'* (Carol).

For Melanie, writing about smoking and pregnancy interventions, change was not potential; she was already trying to achieve it. Her deliberations on freedom, autonomy and the nature of the relationship between herself and those with whom she worked led her to the following course of action:

*'I requested to change my method of working within the Smoking and Pregnancy programme to a community development style and felt that I put a good case forward for this request....'* (Melanie).

The request was not accepted, but Melanie held out the hope that wider organisational change might provide the route to enable alteration to her own practice:

*'From 1993 within our* [health promotion] *unit we have experienced tremendous changes at local, district and county levels. We have had many changes of staff, most of our new members are very aware of the benefits of community development, so I will have much support in this new area for me.... My project plans for 1996 involve myself working in an area of known deprivation....'* (Melanie).

Melanie demonstrates strong certainty of purpose. Rather in contrast, Mandy's reflections on the primary school self esteem project showed diffidence about her feelings towards practice (and any alteration to it) as a result of change in attitude:

*'Most importantly* [writing the critical report].... *has made me look at my own value base- what drives me in health promotion? It has also made me re- evaluate my work with teachers, in that my bid to be an "advocate" for pupils rights as I see them am I denying teachers the right to be treated with respect as "people"? The debate goes round and round in my head but an awareness of this issue enables me to reevaluate mine and others motives in school based health promotion. To what end I am not sure....'* (Mandy).

Generally, the writings presented a far from clear picture of the relationship between change in knowledge and attitude, and alteration in behaviour (or even the wish or capacity to change in this respect). This was partly because of the complexity of feeling inspired by philosophical thinking and writing. Recall Mandy's words:

*'The debate goes round and round in my head.... To what end I am not sure....'* (Mandy).

In the case of others- David for example- clearly there had been changes in attitude. Moral theory had provided him with a framework for critiquing and reflecting on Tackling Drugs Together. However, there was little he could do to change his practice because of the organisational and political imperatives with which he had to work. Attitude alteration could be striking but fail to result in changes to behaviour because of the strength of external influences on individuals.

The political nature of health promotion- and its strong susceptibility to external influence (importantly including 'non- health' influence)- has frequently been demonstrated during this research. The vulnerability of my research participants to influence- making it hard or impossible to change practice despite changes in knowledge and attitude- carries an important point. In Chapter Eight, I reviewed

Daryl Koehn's case for seeing pledging as the ground of professional ethics. Professionals pledge themselves to ethical action. For a number of theoretical reasons, I argued that the professional pledge cannot apply to those engaged in the promotion of health. Yet even if conceptual and theoretical difficulties did not exist with the notion of 'pledging health promotion', it is still problematic in a practical sense for those engaged in the field.

Much of the writing of my participants clearly demonstrates the difficulty they are likely to have in converting changes in knowledge and attitude to alterations in practice. Limits to their capacity in this respect relate to political and organisational influence; to uncertainty about what action to undertake; or to what might 'work' (however that is understood). Carol, for example, talks above about *'intuitive and innovative methodology'* but admits that she does not know what this might actually prove to be. Thus it becomes apparent that a practitioner might want to 'pledge' health promotion (crudely put, have a particular attitude towards her or his clients and the nature and purpose of their relationship); but be unable to enact the pledge. That is to say, he or she just may not have the capacity to turn attitude to action.

Of course, it may be difficult for many- even those working in the paradigmatic professions- to turn pledging into action. But given the uncertainties in the nature of health promotion activity and the strong influences to which it is subject; turning pledges to action does seem peculiarly problematic for those working in health promotion. As already discussed, an important element of Koehn's argument is that the general pledge is underpinned by much more specifically detailed relationships and duties. Aside from conceptual difficulties for health promotion in the idea of the general pledge; there are many practical problems associated with the underpinning detail, as my participants have demonstrated in their reflections on moving from attitude change to practice alteration.

## 3. What Might be Required in the Moral Reconstruction of Health Promotion?

In Chapters Seven and Eight, I identified ways in which bioethics, together with understanding of the nature of professional ethics, might be of help in establishing and dealing with the moral difficulties presented by health promotion. Added to this now are the reflections of my research participants on how they have dealt with the problematic practice about which they have been writing. I want to build upon this theoretical and practical understanding of the potential help for dealing with difficulties to mark out what might be required to be done if health promotion is to be reconstructed in a moral sense.

This 'marking out' is in part a series of acknowledgements of the difficulties presented by health promotion in a moral sense. These have come, of course, from the theoretical and empirical work described and discussed in this thesis. It is also a pointing towards some of the sources of help- from bioethics and professional ethics- that could support moral reconstruction. Thus my 'marking out' is a representation of this thesis as a whole: an identification of problems; and an exploration of how these could possibly be dealt with.

In describing what follows as a 'marking out', there is no intention to imply that the ethical difficulties within the field of my interest can be dealt with easily. As this research has shown, the field is too conceptually and practically messy for easy solutions. However, on the basis of the explorations I have undertaken, it seems that what follows should be taken into account if the ethical problematic of health promotion is to be treated seriously.

**Markers in the moral reconstruction of health promotion**

The territory of health promotion is filled with values. Values are present, and are being acted on, in the work of health promotion theorists; and in the practical activity of those engaged in or controlling the field. The values of those involved in health promotion at theoretical or practical level are not uniform. Moral dispute is therefore inevitable.

Values drive health promotion practice. Because different and competing values exist, competing forms of practice will also be driven forward. The question therefore becomes one of deciding on the relative acceptability of these competing values (and therefore on the approaches and activities they imply). Asking, and attempting to answer, this question is of central importance for those working in health promotion.

It is extremely hard- probably impossible- to construct a case for any value associated with health promotion being seen as overriding. It is also probably impossible to construct a case for health promotion as a value itself being overriding. However, it is possible to construct a 'long list' of values that might be connected to health promotion (for example, individual freedom and social justice). Identifying and justifying such a list of values is a key task for those concerned with health promotion.

Some of this 'long list' of values will be necessary values. There will be some values necessary for the maintenance and development of social structures. There will also be some values necessary for the maintenance and development of individual well-being. There will not always be complete alignment between necessary individual, and necessary social, values. There will also, inevitably, always be a need for the individual to decide which values are important to him or her. Thus a tension will exist- at least sometimes, and possibly frequently- between the goals of health

promotion and the wishes of individuals. It is essential that those working in health promotion recognise the possibility or likelihood of such tension.

Disagreement will frequently- possibly always- be evident as to the nature of the value of 'health' that is being promoted. Separate conceptions of health- for example that it is the 'absence of disease', or the 'foundations for achievement'- are likely often to be disputed. The cultural and professional context in which much health care work takes place may make it hard for health promotion practitioners to develop the professional capacity to promote health in any broad sense; for example, as the 'foundations for achievement'. This is simply because so much health care work is oriented around conceptions of health as disease absence. Again, this may create tension or dissonance for health promotion practitioners.

It is possible to move towards constructing a set of moral obligations for those engaged in health promotion work. On the basis of understanding developed in relation to the broader field of health care, it seems that the following general obligations are likely to be of importance to health promotion practitioners: to respect autonomy; to avoid harm; to produce benefit; and to contribute to justice. Framing obligations can provide a way for practitioners to focus on and understand the dilemmas associated with work in the field of health promotion. However, framing obligations may not enable difficulties to be resolved in all (possibly even many) morally problematic cases. Obligations may not point to definitive courses of action; indeed, there are likely to be occasions when we find it hard to choose between competing obligations.

More broadly, the post- modern context may make it particularly problematic to agree on a set of consensus values and obligations for the field of health promotion. However, understanding this context may help in developing an appreciation of why it is just so hard to agree on 'the values and obligations of health promotion'.

As well as reference to ethical theory to support an understanding of obligations that might be held by health promotion practitioners; it is important to acknowledge that individuals have the capacity to think morally and make ethical judgements. Attention therefore needs to be paid not only to the 'outside in' judgements that are made on health promotion activities; but to encouraging practitioners themselves to make 'inside out' judgements on the field.

There is a need to examine the extent of inter- occupational agreement on the nature and purpose of health promotion. There is also a need to recognise that any process of professionalisation of the 'occupation' of health promotion may pose difficulties: for those working in the occupation; for other occupational groups; and for 'clients' of the field. Any process of professionalisation should not be regarded as morally neutral. Measured consideration of the worth of professionalising and the extent of agreement on purpose may make it possible to frame a provisional 'pledge' for those engaged in health promotion activity. Such a pledge- binding the interests of practitioners and those they serve- may to some extent help to ground trust in the field.

**4. Banishing the Unexamined Life: (i) The Process of Understanding for Myself**

Recognition of these markers for the moral reconstruction of health promotion has been achieved through my thinking in new ways and exploring areas that I may not have initially believed would contribute to developing understanding of the difficulties in which I am interested. It is this process which has enabled me to move from the 'swampy lowland' that forms part of the 'topography of professional practice', where 'messy confusing problems defy technical solution....' (SCHON, 1990: 3).

If I wished to understand the moral problems of health promotion, I needed to understand the nature of health promotion itself. This led me to provisional formulation of an understanding of the nature of health promotion through theory. At this early point, it became clear to me that the lack of a unified conception of health promotion- either as theory or practice- meant it was important to hear different 'voices' speaking. It quickly became clear that in seeking out different voices, they were also likely to be offering separate perspectives on the problematic of understanding health promotion.

Seeking a historical perspective was important because in many ways health promotion can be understood by the kinds of things it is and does. Establishing the nature of how and why 'health promoting things' have been done in the past (and with what constraints) is part of building up a picture of how and why there are difficulties in the present. The identification of five dimensions of a history of health promotion: its social and political context; epidemiology and disease treatment; theoretical debate; development in settings; and development as an occupation (or occupational element); suggested a high degree of complexity to the historical tale. It became clear that the strong political and ideological elements of this history were likely to have contributed to the problematic.

Up to this point in my thesis, I had been listening almost exclusively to theoretical voices; and critically examining key assumptions they appeared to be making. Such assumptions were exemplified by the 'moral case' for health promotion with which I critically engaged. It was important for me now to establish whether the unease I felt about the nature of health promotion in a moral sense was shared by others. I was not, as it has been made clear, seeking generalisability for my own theorising. My claims for the practitioner voices I sought out were limited to confirming that **some others** felt equally that health promotion contained ethical difficulties.

The perspectives offered by voices from bioethics and from professional ethics (ethics **for** and **of** professions) appeared fairly naturally. If myself and my practitioner research participants believed health promotion to be facing moral difficulties- as had by now been confirmed- then bioethics might prove to be a clear source of help. As I discovered in Chapter Seven, the 'bioethical enterprise' had been of major importance in providing moral re-grounding for the broader health care arena, whose ideology and practices had been under strong critical gaze from about the mid- 1970s onwards. Moreover, it was clear that my research participants had themselves sought help from bioethics; again, it was important for me to understand what might have been helpful to them. Equally, it was apparent from my historical analysis that understanding of the nature of health promotion as a professional activity (and of the project to 'professionalise' the occupation of specialist health promotion) had raised substantial ideological tensions. These tensions represented competing values. Was there any way in which conceptualisations of the moral nature of the professions might support a new- ethical- understanding of health promotion as professional activity? So I sought help from the broader territory of professional ethics.

Analysing the possibilities of help offered to health promotion by bioethics and professional ethics led me, in turn, to believe that a number of markers could be set out to guide any project of reconstructing health promotion in a moral sense. The markers contain both acknowledgement of the difficulties faced by any attempt at health promotion's moral rebuilding; and an indication of what could be done, albeit in the general context of an acutely messy problematic. Their presence towards the end of this thesis is important. They are landmarks developed following exploration of a large and uncertain territory. As such, the markers are representations of a reflective journey during which I have engaged with problems in order better to understand and deal with them.

## 5. Banishing the Unexamined Life: (ii) The Process of Understanding for My Research Participants

I want now to continue my suggestion that my research participants equally engaged in processes of understanding as a result of the writing they did. I have already argued that their developing awareness and use of moral theory enabled alterations in attitude, on their part, towards the problems they had used their assignments to discuss. Now I am going to describe and discuss how the process of writing itself supported illuminations of understanding and changes in perception and attitude. My participants employed both professional and personal perspectives- wove stories and argument through writing using these- to understand the difficulties about which they were thinking.

It is possible to distinguish between two styles of writing in which my participants engaged, used to support the stories they were trying to tell and the arguments they were attempting to make. Use was made of a rational, technical style to convey what can be characterised as a professional perspective; and of a much less formal- sometimes almost confessional- style to convey personal perspective. While this distinction can be made, it is important to be clear that often the two styles were intertwined and used interchangeably, with great complexity.

Iris, however, writing about water fluoridation, confined herself to technical style and professional perspective:

*'What is the aim of fluoridation? B..... Health Authority will not consider fluoridation unless there is a cost benefit, so it may be assumed that their aim is to save money. They are the purchasers of healthcare and have a limited budget which must be distributed fairly: The LDC* [Local Dental Committee] *would see the aim as reduced treatment needs and positive attitudes towards dental attendance, happier patients*

*with better health. As dental disease is preventable, I have always thought that fluoridation is an ideal way of helping to achieve better dental health and hence general health, for all. The dental perspective is one of looking at the consequences of not fluoridating and the benefits which would ensue if fluoridation were implemented. I have thought that fluoridation might be feasible for the larger conurbations, where decay rates are greatest, even if not cost effective for the whole county....'* (Iris).

Iris is clearly trying to build rational argument for the intervention being considered through use of technical style and professional perspective. Words such as 'feasible' and 'implemented': and phrases such as 'the consequences of not fluoridating' and 'even if not cost effective for the whole county'; are clearly part of the technical language of professionals, in Iris's case someone who works in community dentistry. The personal as used in 'I have always thought' is quickly followed by a move to a more distant consideration of general population health. Interestingly, the writing above appears in a section of Iris's report entitled 'Personal Perspective'. Yet the perspective is rather more clearly that of a professional commenting on the state of affairs.

Equally Moira, writing about nurses' understanding of the concept of autonomy, uses technical style to convey professional perspective:

*'I agree that nurse teachers have an enormously important role in shaping the future of the profession in relation to health promotion, but in many cases we remain passive, conservative and hierarchical. Education is more than just the transmission of knowledge and skills it is also the acquisition of cultural values and beliefs, maintaining the status quo which could cultivate the attitudes and character traits desired by teachers....'* (Moira).

Use of the personal pronoun at the beginning of this quote is succeeded by a referral back to the impersonal 'we'. Words such as 'transmission' and 'hierarchical': and phrases such as 'transmission of knowledge and skills' and 'acquisition of cultural values and beliefs'; are academic, technical- the language of the professional.

On the other hand, there are clear examples of personal perspectives informing understanding and reflection, developed through distinctly less formal voices. Liz's writing on sensible drinking campaigns is a case in point. From a beginning largely about comparing determinism and existentialism as separate philosophical positions on the issue of human freedom- and confining herself to an academic, technical style in doing so- she quickly moves to the personal. Indeed, she takes centre- stage and tells a story about herself:

*'In some ways I find myself identifying with both existentialism and determinism. Even as a child I liked to think of myself as "strong willed" and "independent" but it came as quite a revelation to me when I realised that my so - called autonomous actions were very firmly grounded in my parents beliefs and principles many of which I realised I did not ascribe to. However, it took a great deal of introspection and growing self - awareness to appreciate this and I believe it is process which can never be fully completed.... Conversely, I sometimes feel that we construct our own restrictions maybe, for example, out of a sense of fear. When my partner decided to end our relationship I felt completely disempowered. However, I am sure that Sartre would have argued that, in a sense, this totally opened up my range of choices in life rather than diminishing them....'* (Liz).

The prominence of the personal pronoun in this extract is striking (in total, there are 13 uses of 'I', 'me' and 'myself' within the space of two fairly short paragraphs). There is a strong sense of disclosure. This becomes even stronger later in the piece when

direct connections are made between Liz's own personal health experience and the subject she is writing about:

*'Nearly a decade ago I suffered an episode of both bulimia nervosa and depression. The medical profession focused their attention on the bulimia since they assumed that this was the* cause *of the depression and concluded that the depression would automatically evaporate once the eating disorder was addressed. Infact, the bulimia was only a symptom of the depression. As a consequence, treating the symptoms without getting to the root of the problem had nearly fatal results.... The point I am trying to illustrate is that alcohol, like food, can play a profound part in people's lives....'* (Liz).

Thus Liz has made use of her own personal story to support understanding of the ethical problem related to health promotion that she is considering.

Liz's writing on sensible drinking is highly distinctive in the sense of disclosure it conveys. However, other reports use personal perspectives to illuminate understanding. Here is Tim, writing about the voluntary group concerned with female sex industry workers:

*'My Christian ethics include a sense of duty.... not out of legalism but out of love for God, and includes Aristotelian eudaimonism poorly interpreted as, "don't worry- be happy". Attempts to "do the right thing" have caused problems from time to time, not least because the motive cannot always be actioned successfully and is open to misinterpretation. I was unhappy when, as I remember, it was labelled, wrongly in my opinion, as a "desire to please" at a psychodynamic counselling training assessment some years ago. Assumption about beliefs and perceived responses as a result can be offensive. "Go easy on morals...." was suggested at a job interview for my first post in health promotion, my application form contained information about my background. I*

*always have, I'm happy to discuss my beliefs, if invited, but I'm not "out" as a Christian because it's important to respect other people's autonomy....'* (Tim).

In the writing of Liz and Tim, for example, personal stories underpin moral or professional argument. Tim's revelation about his beliefs, and the central importance to him of autonomy, coincide in an apparently purposeful way with his reflections about the organisation he is involved with. Liz grounds her moral argument for recognition of the interests and rights of others in her own personal experience of depression. In other instances, personal perspectives are largely unrelated to theoretical or professional argument. Here is part of John's assignment. It will be remembered that his focus is the introduction of smoking policies in schools:

*'Some people genuinely seem unable to regulate their lives without the support of smoking.... The tobacco industry's advertising plays on these themes although they claim their adverts only encourage people to brand switch and do not entice the young to smoke. This aspect is very much the evil side of the tobacco industry and schools need to develop young people's ability to perceive the more sinister nature of advertising....'*

*'It would seem that all the world is an ashtray. Smokers deposit hundreds of tons of ash on the ground, and discard something like three hundred million butts in Great Britain every day. Walk down any unswept high street to see at first hand evidence of this... Why should people, the majority of whom do not smoke, be subjected to this carpet of fag ends? It does not seem just or fair....'* (John).

John's use of words such as 'sinister' and 'evil'- together with the rhetorical question towards the end of this extract- show a strongly personal voice emerging. It is quite evident that there is personal commitment on his part to the issue of smoking prevention. However, the relationship between this strong personal voice and more

theoretical or professional perspectives is very slender- simply because the latter do not really exist to any great extent.

On the other hand, Anthony, writing about HIV combination therapy, integrates professional, philosophical and personal perspectives through an almost seamless switching between different voices:

'*Arguments about distributive justice* [in relation to combination therapy] *centre on the justification I can provide for giving different amounts of time to different people: Robert whom I see fleetingly when he visits the Consultant in clinic, Tina whom I've visited at home monthly since her husband's death and her subsequent diagnosis two years ago. How can I morally justify such disparity...?'* (Anthony)

Within this one short paragraph, Anthony has moved from philosophical perspective through an element of personal story telling to a question emerging from both. The question- and a response to it- will illuminate understanding, which itself has emerged from the integration of perspectives.

The style of Carol's assignment is clearly a personal one, achieved at least in part through her focus on the characters in the story she is telling- a story in which they play an active part as her interviewees. She is careful in her introductions to them:

*'People I chose to interview:*

*'Janie- one of the young people who visited the* [health] *mobile, was involved in setting up the project and was the last to leave!*

*'John- a volunteer worker on the L.... project.*

*'Barry- an outreach worker and volunteer co-ordinator at Health Promotion, working with the gay community....*

*'Richard- sexual health programme manager....'* (Carol).

Interviews are used to move her story forward; they provide it with a personal and compelling quality. There is a strong sense in which listening to, and reflecting on, a range of other voices- mediated through her writing- has supported her understanding of the moral problematic. Here she is reflecting on what the young people involved in her community outreach project valued about it and recalls Janie, articulating the view that it had given her a sense of independent direction and autonomy:

*' "You were not the teacher or the boss; you asked us what we wanted and we all made the decisions We didn't have to worry about what anyone thought. If we wanted to say something we could just say it...."*

*'However it is apparent there were times when autonomy was compromised*

*' "I remember when we went to see the mayor and there was so much I wanted to say that wouldn't come out and he asked me something and I went all red. I was thinking, oh! Carol, please say something...." '* (Carol).

Janie's voice supports the development of Carol's thinking: on difficulties faced by those promoting health in helping young people make autonomous choices; and on the nature of autonomy creation as a gradual process. But what Carol is doing is even richer and more complex than this. She is representing, but also articulating on behalf of, and empathising with, Janie. She is using these health promotion- related skills (KATZ AND PEBERDY, 1997) to draw out a story illuminating understanding of the moral problem identified. Carol mediates Janie's voice with her empathy- professional

skill and personal quality- and uses it as a way of clarifying problems and determining resolutions.

## 6. Conclusion: Towards New Ways of Seeing Moral Problems in the Theory and Practice of Health Promotion

I have argued that for both myself and my research participants, our progress in understanding the ethical difficulties of health promotion has been characterised by seeing things in new or different ways; and by making connections between different parts of our understanding and experience- theoretical, professional and personal. It is in the willingness to draw new (possibly previously unconsidered) connections that understanding is extended. We both employed- and mediated between- a range of 'voices' to interpret and illuminate the messy problematics with which we were faced.

In a crucial sense, new or altered ways of seeing are **required** of those attempting to understand health promotion's ethical difficulties. Schon (1990) argues that when a professional is confronted with a unique situation, she or he cannot rely on technical competence to frame a solution to the problem:

'In situations of value conflict, there are no clear and self- consistent ends to guide the technical selection of means....' (SCHON, 1990: 6).

The world of practice is complex and may involve both conflict and inherent instability. My own accounts of history, theory and practice have demonstrated this in relation to the field of my interest- health promotion. My research participants have shown the extent to which they struggle with competing values in their own practice world. In order to understand and deal with this world, more than simply technical competence is required. Schon argues that artistry is also necessary. Artistry is the

ability to make skilful and spontaneous judgements, leading to the 'right' action, although it will probably not be possible to explain how judgement and action were actually made in terms of rules or procedures. This process can be conceived of as 'knowing- in- action' (SCHON, 1990: 24).

When knowing- in- action goes wrong, it is possible to respond to error in two separate ways: reflection **on** action; and reflection **in** action. Reflection- in- action is distinguished from other kinds of reflection through its immediate significance for the action and, like knowing- in- action, is a process which it may be hard, or even impossible, to describe in a rational- technical way.

Understanding the practice of health promotion requires artistry, 'knowing- in - action'. But as I and my participants have discovered, 'knowing- in- action' in health promotion can go wrong. There is a requirement, then, for practitioners to be able to reflect on, and in, action.

The processes of learning and writing, and the use of multiple perspectives within this writing, has enabled reflection on action. Moreover, the process of writing has resembled the Schonian notion of reflection in action. Using multiple personal and professional perspectives has enabled my participants to see the world in a new or different way:

*'A s a rational moral agent, the woman's freedom to do as she wishes with her own body should be paramount....'* (Judith).

*'For Clare whose children are not yet autonomous adults, I value the potential of anti-HIV drugs for securing a longer life but I also respect her autonomy....'* (Anthony).

*'Most importantly* [writing the critical report].... *has made me look at my own value base- what drives me in health promotion....?'* (Mandy).

For Judith, Anthony, Mandy and many of my other participants, practice has been re-seen. Values become central in this new way of seeing the world; and in acknowledging the centrality of values, it becomes possible to establish new ways of understanding and dealing with the problems of practice. These new ways of seeing and understanding have been made possible because writing has allowed the opportunity to build rich and detailed pictures of a complex world. Creation of such pictures has, in effect, allowed the possibility of practice being simulated. In this simulation, a kind of reflection- in- action by proxy has been allowed. Because the world has been seen in a new way in simulation, knowing- in- action and reflection-in- action will be facilitated in the real world of practice.

Examination of this process will be the next stage of research. It will be supported by what has been learnt during this stage: more explicit acknowledgement of the moral difficulties facing health promotion and what might begin to support their being dealt with; and the value of reflection and writing in understanding and working towards resolution of the problematic. There is a great deal more to do, but this research has established the foundations for further work.

## REFERENCES

ADAMS, L (1993). Health Promotion at the Crossroads. Society of Health Education and Health Promotion Specialists.

ADAMS, L AND PINTUS, S (1993). A Challenge to Prevailing Health Promotion Theory and Practice- Back to Basics. Unpublished. Draft paper presented to the National Health Promotion Manager's Conference, Penrith, 28-29 October.

ALCORN, K, POPPA, A, KING, E AND NICHOLSON, M (1998). National AIDS Manual: HIV and AIDS Treatment Directory. National AIDS Manual.

ANDERSON, D (1990). Smaller is healthier. Health Education Journal, **49**, 1, 17-18.

ARISTOTLE (1955). Ethics (translated by JAK Thomson). Penguin.

ARMSTRONG, D (1993). From clinical gaze to regime of total health. In Beattie, A *et al* (eds.), Health and Well- Being: A Reader. Macmillan.

ASHTON, J AND SEYMOUR, H (1993). The setting for a new public health. In Beattie, A *et al* (eds.), Health and Well- Being: A Reader. Macmillan.

ASHWORTH, P (1997). Breakthrough or bandwagon? Are interventions tailored to stages of change more effective than non- staged interventions? Health Education Journal, **56**, 166-174.

BAELZ, P (1979). Philosophy of health education. In Sutherland, I (ed.), Health Education: Perspectives and Choices. George Allen and Unwin.

BARIC, L (1986). The meaning of words: health promotion. Reprinted in Steel, S (ed.), Working in Health Education. National Extension College.

BARIC, L (1996). Health Promotion and Health Education: Handbook for Students and Practitioners. Barns Publications.

BEATTIE, A (1984). Health education and the science teacher: invitation to a debate. Education and Health, January, 9-16.

BEATTIE, A (1991). Knowledge and control in health promotion: a test case for social theory. In Gabe, J, Calnan, M and Bury, M (eds.), The Sociology of the Health Service. Routledge.

BEAUCHAMP, T AND CHILDRESS, J (1994). Principles of Biomedical Ethics (fourth edition). Oxford University Press.

BERRIDGE, V (1996a). AIDS in the UK: The Making of a Policy. Oxford University Press.

BERRIDGE, V (1996b). Crisis what crisis? Health Service Journal, 8 August, 20-23.

BLACKBURN, C (1991). Poverty and Health: Working with Families. Open University Press.

BLYTHE, M (1986). A century of health education. Health and Hygiene, 7, 105-115.

BOORSE, C (1975). On the distinction between disease and illness. Philosophy and Public Affairs, 5, 49-68.

BREMNER, M (1994). Professional Development in Health Promotion: A Strategic Framework. South Thames Regional Health Authority.

BUNTON, R, NETTLETON, S AND BURROWS, R (eds.) (1995). The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle and Risk. Routledge.

CALDECOT CENTRE (1997). Anti- HIV Drug Therapy (Starting Combination Therapy). Caldecot Centre, King's College Hospital NHS Trust.

CALNAN, M (1987). Health and Illness: The Lay Perspective. Tavistock Publications.

CALOUSTE GULBENKIAN FOUNDATION (1984). A National Centre for Community Development: Report of a Working Party. Calouste Gulbenkian Foundation.

CAMPBELL, A (1976). Health and human freedom. Journal of the Institute of Health Education, 14, 3, 67- 70.

CAMPBELL, A (1990). Education or indoctrination? The issue of autonomy in health education. In Doxiadis, S (ed.), Ethics in Health Education. John Wiley and Sons Ltd.

CARTER, D (1998). Using attitude surveys in medical ethics research and teaching: the example of undergraduate willingness to treat HIV- infected patients. Medical Education, 32, 121-126.

CHADWICK, E (1842). Report on the Sanitary Conditions of the Labouring Populations of England. Her Majesty's Stationery Office.

CHAND, S, TILSTON, J AND VERRALL, J (1989). Association of HEOs- Recruitment and Employment. Association of HEOs.

COHEN, JM AND COHEN, MJ (1980). The Penguin Dictionary of Modern Quotations (second edition). Penguin.

COHEN, L AND MANION, L (1989). Research Methods in Education (third edition). Routledge.

COLE, J (1995). As It Seemed to Me: Political Memoirs. Weidenfeld and Nicolson.

CORNWELL, J (1984). Hard- Earned Lives: Accounts of Health and Illness from East London. Tavistock Publications.

COTTER, C (1994). Professional Development of Health Promotion Specialists: Exploring Diploma Course Provision. Summary of a dissertation prepared for the MSc in Health Education and Health Promotion, South Bank University, London.

CREME, P AND LEA, M (1997). Writing at University. Open University Press.

CRIBB, A (1993). The borders of health promotion: a response to Nordenfelt. Health Care Analysis, **1**, 2, 131-137.

CRIBB, A AND DINES, A (1993). Health promotion: concepts. In Dines, A and Cribb, A (eds.), Health Promotion: Concepts and Practice. Blackwell Scientific.

CRISP, R, HOPE, T AND EBBS, D (1996). The Astbury draft policy on ethical use of resources. British Medical Journal, **312**, 1528- 1531.

DARK, P (1998). Consultation on the future of health promotion. SHEPS Debate, **1**, 5, 15- 17.

DAWSON, A (1994). Professional codes of practice and ethical conduct. Journal of Applied Philosophy, **11**, 2, 145- 153.

DENT, T (1999). Our time has come. Health Service Journal, 27 May, 27.

DEPARTMENT OF EDUCATION AND SCIENCE (1988). Education Reform Act. Her Majesty's Stationery Office.

DEPARTMENT OF HEALTH (1989). Working for Patients: The Health Service Caring for the 1990s (Cmnd 55). Her Majesty's Stationery Office.

DEPARTMENT OF HEALTH (1990). The National Health Service and Community Care Act 1990. Her Majesty's Stationery Office.

DEPARTMENT OF HEALTH (1993a). Changing Childbirth. Her Majesty's Stationery Office.

DEPARTMENT OF HEALTH (1993b). Working Together for Better Health. Department of Health.

DEPARTMENT OF HEALTH (1995a). Breast Feeding: Good Practice Guidance to the NHS. Department of Health.

DEPARTMENT OF HEALTH (1995b). Sensible Drinking. Department of Health/ Inter- Departmental Working Group.

DEPARTMENT OF HEALTH (1995c). Variations in Health: What Can the Department of Health and the NHS Do? (Report of the Variations Sub- Group of the Chief Medical Officer's Health of the Nation Working Group.) Her Majesty's Stationery Office.

DEPARTMENT OF HEALTH (1998). The New NHS: Modern, Dependable. The Stationery Office.

DEPARTMENT OF HEALTH AND SOCIAL SECURITY (1976). Prevention and Health: Everybody's Business. Her Majesty's Stationery Office.

DINES, A AND CRIBB, A (eds.) (1993). Health Promotion: Concepts and Practice. Blackwell Scientific.

DOUGHERTY, CJ (1993). Bad faith and victim-blaming: the limits of health promotion. Health Care Analysis, **1**, 111-119.

DOWNIE, RS, TANNAHILL, C AND TANNAHILL, A (1996). Health Promotion: Models and Values (second edition). Oxford University Press.

DUNCAN, P (1990). To screen or not to screen? A question of ethics. Health Education Journal, **49**, 3, 120-122.

DUNCAN, P (1995). Ethical audit: should it concern health promoters? What can they do? Journal of the Institute of Health Education, **33**, 3, 72-75.

DUNCAN, P (1997). Promoting Health. South Bank University Distance Learning Centre.

DUNCAN, P AND CRIBB, A (1996). Helping people change: an ethical approach? Health Education Research, **11**, 3, 339-348.

DWORKIN, R (1995). Life's Dominion: An Argument About Abortion and Euthanasia. Harper Collins.

EASTON, D (1953). The Political System. New York: Knopf.

EDGAR, A (1994). The value of codes of conduct. In Hunt, G (ed.), Ethical Issues in Nursing. Routledge.

ELLIOT, J (1993). Reconstructing Teacher Education. Falmer Press.

ENGLEHARDT, HT (1975). The concepts of health and disease. In Englehardt, HT and Spicker, S (eds.), Evaluation and Explanation in the Biomedical Sciences. Dordrecht: Reidel.

ENGLEHARDT, HT (1976). Ideology and etiology. Journal of Medicine and Philosophy, **1**, 256- 268.

ENGLEHARDT, HT JR. AND WILDES, KW (1994). The four principles of health care ethics and post- modernity: why a libertarian interpretation is unavoidable. In Gillon, R and Lloyd, A (eds.), Principles of Health Care Ethics. John Wiley and Sons Ltd.

ENGLISH NATIONAL BOARD FOR NURSING, MIDWIFERY AND HEALTH VISITING (1987). Managing Change in Nurse Education- Pack 1: Preparing for Change. English National Board for Nursing, Midwifery and Health Visiting.

ERAUT, M (1994). Developing Professional Knowledge and Competence. Falmer Press.

EWLES, L (1993). Paddling upstream for 50 years: the role of health education officers. Health Education Journal, **52**, 3, 172-181.

EWLES, L AND SIMNETT, I (1992). Promoting Health: A Practical Guide to Health Education (second edition). Scutari Press.

FAGGE, D (1993). Personal communication (July).

FAULDER, C (1985). Whose Body is It?: The Troubling Issue of Informed Consent. Virago.

FEINBERG, J (1969). Introduction. In Feinberg, J (ed.), Moral Concepts. Oxford University Press.

FIELDING, M (1996). Empowerment: emancipation or enervation? Journal of Education Policy, **11**, 3, 399-417.

FORREST, P (1986). Breast Cancer Screening: Report to the Health Ministers of England, Wales, Scotland and Northern Ireland. (The Forrest Report.) Her Majesty's Stationery Office.

FRANCOME, C AND MARKS, D (1996). Improving the Health of the Nation: The Failure of the Government's Health Reforms. Middlesex University Press.

FRENCH, J (1985). To educate or promote health? That is the question. Health Education Journal, **44**, 3, 115-116.

FRENCH, J (1990). Boundaries and horizons, the role of health education within health promotion. Health Education Journal, **49**, 1, 7-10.

FRENCH, J (UNPUBLISHED). The history and development of public health as a concept and professional endeavour in the UK. Unpublished draft chapter from a PhD thesis in progress, Leeds Metropolitan University.

FULFORD, KWM (1993). Bioethical blind spots: four flaws in the field of view of traditional bioethics. Health Care Analysis, **1**, 155- 162.

GENERAL MEDICAL COUNCIL (1993). Tomorrow's Doctors. General Medical Council.

GILLON, R (1990a). Health education: the ambiguity of the medical role. In Doxiadis, S (ed.), Ethics in Health Education. John Wiley and Sons Ltd.

GILLON, R (1990b). Philosophical Medical Ethics. John Wiley and Sons Ltd.

GILLON, R (1994). Medical ethics: four principles plus attention to scope. British Medical Journal, **309**, 184-188 (16 July).

GILLON, R AND LLOYD, A (eds.) (1994). Principles of Health Care Ethics. John Wiley and Sons Ltd.

GLASSNER, B (1995). In the name of health. In Bunton, R, Nettleton, S and Burrows, R (eds.), The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle and Risk. Routledge.

GLOVER, J (1977). Causing Death and Saving Lives. Penguin.

GOROVITZ, S (1985). Doctor's Dilemmas: Moral Conflict and Medical Care. New York: Oxford University Press.

GOROVITZ, S (1990). Health care advertising: communication or confusion? In Doxiadis, S (ed.), Ethics in Health Education. John Wiley and Sons Ltd.

GOROVITZ, S (1994). Is caring a viable component of health care? Health Care Analysis, **2**, 129-133.

GRACE, VM(1991). The marketing of empowerment and the construction of the health consumer: a critique of health promotion. International Journal of Health Services, **21**, 2, 329-343.

GREENHALGH, T AND TAYLOR, R (1997). Papers that go beyond numbers (qualitative research). British Medical Journal, **315**, 740-743.

HALDANE, J (1986). 'Medical ethics'- an alternative approach. Journal of Medical Ethics, **12**, 145- 150.

HAM, C (1985). Health Policy in Britain (second edition). Macmillan.

HARDEN, RM (1995). Progress in medical education. Medical Education, **29** (Supplement 1), 79-82.

HARE, RM (1986). Health. Journal of Medical Ethics, **12**, 174-181.

HARE, RM (1994). Utilitarianism and deontological principles. In Gillon, R and Lloyd, A (eds.), Principles of Health Care Ethics. John Wiley and Sons Ltd.

HARRIS, J (1985). The Value of Life: An Introduction to Medical Ethics. Routledge and Kegan Paul.

HARRISON, R (1992). A Portfolio Approach to Personal and Career Development: Workbook. The Open University.

HEALTH EDUCATION AUTHORITY (1992). Drinkwise Strategy 1992-1994. Health Education Authority.

HEALTH EDUCATION AUTHORITY (1993a). Giving Up Smoking: Does Patient Education Work?- Summary. Health Education Authority.

HEALTH EDUCATION AUTHORITY (1993b). Helping People Change: Training Course for Primary Health Care Professionals. Health Education Authority National Unit for Health Promotion in Primary Health Care.

HEALTH EDUCATION AUTHORITY (1998a). National Occupational Standards for Professional Activity in Health Promotion and Care: Case Studies. Health Education Authority.

HEALTH EDUCATION AUTHORITY (1998b). National Occupational Standards for Professional Activity in Health Promotion and Care: Results of the Pilot Study. Health Education Authority.

HEALTH PROMOTION WALES (1992). Health for All in Wales: Plan for Action. Health Promotion Wales.

HEALTH SERVICE JOURNAL (1997). Opinion: papering over the cracks? Health Service Journal, 11 December, 17.

HEALTH SERVICE JOURNAL (1999a). Conservatives claim ignorance of tobacco funds. Health Service Journal, 12 August, 2.

HEALTH SERVICE JOURNAL (1999b). Doctors button up as wind of change blows through. Health Service Journal, 18 February, 15.

HER MAJESTY'S STATIONERY OFFICE (1995). Tackling Drugs Together: A Strategy for England 1995-1998. Her Majesty's Stationery Office.

HERTFORDSHIRE HEALTH AGENCY (1995). Mouths Fit for a Lifetime. Hertfordshire Health Agency.

HERZLICH, C (1973). Health and Illness. Academic Press.

HILL, M (1999). Uncovering the Bristol scandal. BBC Online News, 15 March (URL: www.bbc.co.uk/news.)

HIS MAJESTY'S STATIONERY OFFICE (1942). Social Insurance and Allied Services: Report by Sir William Beveridge (Cmnd 6404). His Majesty's Stationery Office.

HOYLE, E (1980). Professionalisation and deprofessionalisation in education. In Hoyle, E and Megarry, J (eds.), World Yearbook of Education 1980. Kogan Page.

HOYLE, E AND JOHN, PD (1995). Professional Knowledge and Professional Practice. Cassell.

HUMAN FERTILISATION AND EMBRYOLOGY AUTHORITY (HFEA) (1994). Donated Ovarian Tissue in Embryo Research and Assisted Conception: Public Consultation Document. HFEA.

HUTTON, W (1995). The State We're In. Jonathan Cape.

ILLICH, I (1977). Limits to Medicine. Pelican.

INDEPENDENT INQUIRY INTO INEQUALITIES IN HEALTH (1998). Report. The Stationery Office.

JESSOP, EG (1991). Screening. Health Education Journal, **50**, 1, 52.

KARHAUSEN, L (1987). From ethics to medical ethics. In Doxiadis, S (ed.), Ethical Dilemmas in Health Promotion. John Wiley and Sons Ltd.

KATZ, J AND PEBERDY, A (eds.) (1997). Promoting Health: Knowledge and Practice. Macmillan.

KAY, J (1998). Evolutionary politics. Prospect, July, 31- 35.

KELLY, M (1996). A Code of Ethics for Health Promotion. Social Affairs Unit.

KENNEDY, I (1983). The Unmasking of Medicine (second edition). Granada.

KITCHER, P (1997). The Lives to Come: The Genetic Revolution and Human Possibilities. Penguin.

KOEHN, D (1994). The Ground of Professional Ethics. Routledge.

LABOUR PARTY (1996). Renewing the NHS: Labour's Agenda for a Healthier Britain. The Labour Party.

LACEY, AR (1976). A Dictionary of Philosophy. Routledge and Kegan Paul.

LALONDE, M (1974). A New Perspective on the Health of Canadians. Ottawa: Ministry of Supply and Services.

LATTER, S (1998). Health promotion in professional education: nursing. Presentation to the Health Education Authority conference, Health Promotion: New Directions in Professional Development, London, 6 March.

LAWN, M (1996). Modern Times? Work, Professionalism and Citizenship in Teaching. Falmer Press.

LAWRENCE, T (1999). A stage- based approach to behaviour change. In Perkins, E, Simnett, I and Wright, L (eds.), Evidence- Based Health Promotion. John Wiley and Sons Ltd.

LEA, M AND STREET, B (1999). Writing as academic literacies: understanding textual practices in higher education. In Candlin, C and Hyland, K (eds.), Writing Texts, Processes and Practices. Longman.

LEA, M AND STREET, B (UNPUBLISHED). Student writing in higher education: an academic literacies approach.

LEATHARD, A (1990). Health Care Provision: Past, Present and Future. Chapman and Hall.

LOCAL GOVERNMENT MANAGEMENT BOARD (1997). National Occupational Standards for Health Promotion and Care (Four Volumes). Local Government Management Board.

LUPTON, D (1993). Risk as moral danger: the social and political functions of risk discourse in public health. International Journal of Health Services, **23**, 3, 425-435.

LUPTON, D (1998). The end of AIDS?: AIDS reporting in the Australian press in the mid- 1990s. Critical Public Health, **8**, 1, 33- 46.

McCORMICK, J (1990). The limits of medicine. Times Health Supplement, June, 7-9.

McKEOWN, K (1995). 'Black to basics': a health promotion interpretation. SHEPS Debate, **1**, 1, 13- 16.

McKEOWN, T (1976). The Role of Medicine: Dream, Mirage or Nemesis. Nuffield Provincial Hospitals Trust.

MACDONALD, G AND BUNTON, R (1992). Health promotion: discipline or disciplines? In Bunton, R and Macdonald, G (eds.), Health Promotion: Disciplines and Diversity. Routledge.

MACINTYRE, A (1985). After Virtue: A Study in Moral Theory (second edition). Duckworth.

MACLEAN, A (1993). The Elimination of Morality: Reflections on Utilitarianism and Bioethics. Routledge.

MACLEOD- CLARK, J (1993). From sick nursing to health nursing: evolution or revolution? In Wilson- Barnett, J and Macleod- Clark, J (eds.), Research in Health Promotion and Nursing. Macmillan.

MARTEAU, T (1989). Psychological costs of screening. British Medical Journal, **299**, 527.

MARTEAU, T (1990). Screening in practice: reducing the psychological costs. British Medical Journal, **301**, 26- 28.

MILL, JS (1962). Utilitarianism (and other writings, edited by Mary Warnock). Fontana.

MINISTRY OF HEALTH (1964). Report of a Joint Committee of the Central and Scottish Health Services Councils on Health Education (The Cohen Report). Her Majesty's Stationery Office.

MITCHELL, L, HARVEY, T AND ROLLS, L (1998). Interprofessional standards for the care sector- history and challenges. Journal of Interprofessional Care, **12**, 2, 157-168.

MORAN, G (1986). Health promotion in local government: a British experience. Health Promotion, **1**, 2, 191-200.

MORRIS, J (1969). Tomorrow's community physician. The Lancet, **ii**, 811.

NAIDOO, J AND WILLS, J (1994). Health Promotion: Foundations for Practice. Bailliere Tindall.

NATIONAL CURRICULUM COUNCIL (1990). Curriculum Guidance Five: Health Education. National Curriculum Council.

NATIONAL STAFF COMMITTEE FOR ADMINISTRATIVE AND CLERICAL STAFF- NHS (1981). The Recruitment, Training and Development of Health Education Officers (The Kirby Report). NHS National Staff Committee for Administrative and Clerical Staff.

NORDENFELT, L (1993). On the nature and ethics of health promotion: an attempt at a systematic analysis. Health Care Analysis, **1**, 121- 130.

NORTHERN IRELAND OFFICE (1992). Regional Strategy for Health and Personal Social Services for Northern Ireland. Her Majesty's Stationery Office.

NORTHERN IRELAND OFFICE (1998). Well Into 2000. Northern Ireland Office.

NORTON, D (1976). Personal Destinies: A Philosophy of Ethical Individualism. Princeton, NJ: Princeton University Press.

NUTBEAM, D (1986). Health promotion glossary. Health Promotion, **1**, 1, 113-127.

OPEN UNIVERSITY (1997). Promoting Health: Skills, Perspectives and Practice: Study File. Open University.

OXFORD UNIVERSITY PRESS (1978). The Concise Oxford Dictionary. Oxford University Press.

PARLE, J, GREENFIELD, S, SKELTON, J, LESTER, H AND HOBBS, F (1997). Acquisition of basic clinical skills in the general practice setting. Medical Education, **31**, 2, 99-104.

PATON, HJ (1948). The Moral Law. Hutchinson.

PECKHAM, S, TURTON, P AND TAYLOR, P (1998). The missing link. Health Service Journal, 28 May, 27- 28.

PINTUS, S (1998). Editorial. SHEPS Debate, **1**, 5, 1- 2.

PRIEST, V AND SPELLER, V (1991). The Risk Factor Management Manual. Radcliffe Medical Press.

PRINCIPLES OF PRACTICE STANDING COMMITTEE (OF THE SOCIETY OF HEALTH EDUCATION AND HEALTH PROMOTION SPECIALISTS) (1992). Notes of meeting held on 23 March.

PROCHASKA, J AND DICLEMENTE, C (1984). The Transtheoretical Approach: Crossing Traditional Foundations of Change. Homewood, IL: Don Jones/ Irwin.

RAWSON, D (1992). The growth of health promotion theory and its rational reconstruction: lessons from the philosophy of science. In Bunton, R and Macdonald, G (eds.), Health Promotion: Disciplines and Diversity. Routledge.

RAWSON, D AND GRIGG, C (1988). Purpose and Practice in Health Education: The Summary Report of the SHER Project. Polytechnic of the South Bank.

REID, D (1999). WHO welcomes launch of UK Public Health Association. Public Health Forum, **3**, 2, 7.

REIDMAN, S AND GUSTAFSON, E (1995). Green mould in the wind. In Carey, J (ed.), The Faber Book of Science. Faber and Faber.

RIVERS, K, AGGELTON, P AND WHITTY, G (1998). Professional Development in Health Promotion. Health Education Authority.

ROLLS, L (1995). Competencies for Professional Development in Health Education Project: The Final Report- A Summary Document. Health Education Authority.

ROYAL COLLEGE OF GENERAL PRACTITIONERS (1981). Health and Prevention in Primary Care: Report of a Working Party Appointed by the Council of the Royal College of General Practitioners. Royal College of General Practitioners.

ROYAL COLLEGE OF GENERAL PRACTITIONERS (1983). Promoting Prevention: A Discussion Document Prepared by a Working Party of the Royal College of General Practitioners. Royal College of General Practitioners.

ROYAL COLLEGE OF GENERAL PRACTITIONERS (1986). Prevention and the Primary Care Team. Royal College of General Practitioners.

RUSSELL, B (1979). A History of Western Philosophy. Unwin Paperbacks.

RUSSELL, J (1995). A Review of Health Promotion in Primary Care: From the GP Health Promotion Contract to Promoting Health with Local Communities. Greater London Association of Community Health Councils.

SCADDING, J (1988). Health and disease: what can medicine do for philosophy? Journal of Medical Ethics, **14**, 118-124.

SCHON, D (1990). Educating the Reflective Practitioner. San Francisco: Jossey-Bass.

SCHUKLENK, U, MERTZ, D AND RICHTERS, J (1995). The bioethics tabloids: how professional ethicists have fallen for the myth of tertiary transmitted homosexual AIDS. Health Care Analysis, **3**, 27- 36.

SCOTTISH OFFICE (1992). Scotland's Health, A Challenge to Us All. Scottish Office.

SCOTTISH OFFICE (1998). Working Together for a Healthier Scotland. Scottish Office.

SECRETARIES OF STATE (1987). Promoting Better Health: The Government's Programme for Improving Primary Health Care. Her Majesty's Stationery Office.

SECRETARY OF STATE FOR HEALTH (1992). The Health of the Nation. Her Majesty's Stationery Office.

SECRETARY OF STATE FOR HEALTH (1998). Our Healthier Nation. Her Majesty's Stationery Office.

SEEDHOUSE, D (1986). Health: The Foundations for Achievement. John Wiley and Sons Ltd.

SEEDHOUSE, D (1988). Ethics: The Heart of Health Care. John Wiley and Sons Ltd.

SEEDHOUSE, D (1994). Fortress NHS: A Philosophical Review of the National Health Service. John Wiley and Sons Ltd.

SEEDHOUSE, D (1997). Health Promotion: Philosophy, Prejudice and Practice. John Wiley and Sons Ltd.

SHICKLE, D AND CHADWICK, R (1994). The ethics of screening: is 'screeningitis' an incurable disease? Journal of Medical Ethics, **20**, 12-18.

SHILTS, R (1988). And the Band Played On: Politics, People and the AIDS Epidemic. Viking.

SIMNETT, I (1991). Certificate in Health Education Open Learning Project Course Workbook: The Nature, Agents and Competencies of Health Promotion. Keele University/ Health Education Authority.

SKRABANEK, P (1988). The debate over mass mammography in Britain: the case against. British Medical Journal, **297**, 971-972.

SKRABANEK, P (1990). Why is preventive medicine exempt from ethical constraints? Journal of Medical Ethics, **16**, 187- 190.

SMITH, D (1993). Options for the Future: Organisational Arrangements for Health Promotion Services. Health Education Authority.

SOAFER, B (1995). Enhancing humanistic skills: an experiential approach to learning about ethical issues in health care. Journal of Medical Ethics, **21**, 31-34.

SOCIETY OF HEALTH EDUCATION OFFICERS (1985). Code of Conduct. Society of Health Education Officers.

SOCIETY OF HEALTH EDUCATION OFFICERS (1988). Society of Health Education Officers Policy Workshop, Harrogate, 26-28 February: Report. Society of Health Education Officers.

SOCIETY OF HEALTH EDUCATION AND HEALTH PROMOTION OFFICERS (1989). The Registration Scheme for Health Education/ Health Promotion Specialists. Society of Health Education and Health Promotion Officers.

SOCIETY OF HEALTH EDUCATION AND HEALTH PROMOTION SPECIALISTS (1991). Register of Health Education and Health Promotion Specialists. Society of Health Education and Health Promotion Specialists.

SOCIETY OF HEALTH EDUCATION AND HEALTH PROMOTION SPECIALISTS (1992). Code of Professional Conduct: Consultation Phase. Society of Health Education and Health Promotion Specialists.

SOCIETY OF HEALTH EDUCATION AND HEALTH PROMOTION SPECIALISTS (1993). Code of Professional Conduct for Health Education and Health Promotion Specialists. Society of Health Education and Health Promotion Specialists.

SOCIETY OF HEALTH EDUCATION AND HEALTH PROMOTION SPECIALISTS (1996). Mandatory registration on hold. Society of Health Education and Health Promotion Specialists News, July, 3.

SOCIETY OF HEALTH EDUCATION AND HEALTH PROMOTION SPECIALISTS (1997a). A Career as a Health Promotion Specialist. Society of Health Education and Health Promotion Specialists.

SOCIETY OF HEALTH EDUCATION AND HEALTH PROMOTION SPECIALISTS (1997b). Code of Professional Conduct for Health Education and Health Promotion Specialists (second edition). Society of Health Education and Health Promotion Specialists.

SOCIETY OF HEALTH EDUCATION AND HEALTH PROMOTION SPECIALISTS (1997c). The Promotion of Health in the UK. Society of Health Education and Health Promotion Specialists.

SOCIETY OF HEALTH EDUCATION AND HEALTH PROMOTION SPECIALISTS (1997d). Recognised Courses for Health Education/ Promotion Specialists. Society of Health Education and Health Promotion Specialists.

SOCIETY OF HEALTH EDUCATION AND HEALTH PROMOTION SPECIALISTS (1998a). Health Improvement Programmes and the Application of a Social Model of Health. Society of Health Education and Health Promotion Specialists.

SOCIETY OF HEALTH EDUCATION AND HEALTH PROMOTION SPECIALISTS (1998b). Principles of Practice Briefing Papers. Society of Health Education and Health Promotion Specialists.

SOCIETY OF HEALTH EDUCATION AND HEALTH PROMOTION SPECIALISTS (1998c). SHEPS financial plan 1999. SHEPS Newsletter, 3, December, 8.

SOUTH BANK UNIVERSITY (1995a). Course Guide: Postgraduate Studies in Health Promotion. South Bank University.

SOUTH BANK UNIVERSITY (1995b). Unit Guide- MSc Add- On in Health Promotion: Philosophy and Health Promotion 1995-6. South Bank University.

SOUTH BANK UNIVERSITY (1996a). Postgraduate Studies in Health Promotion. South Bank University.

SOUTH BANK UNIVERSITY (1996b). Unit Guide- MSc Add- On in Health Promotion: Philosophy and Health Promotion 1996-7. South Bank University.

STATIONERY OFFICE (1997). The New NHS: Modern, Dependable. The Stationery Office.

STOATE, HG (1989). Can health screening damage your health? Journal of the Royal College of General Practitioners, **39**, 193-195.

STRAUSS, A AND CORBIN, J (1990). Basics of Qualitative Research: Grounded Theory Procedures and Techniques. Newbury Park, CA: Sage Publications.

SUTHERLAND, I (1979). Health education: history and background. In Sutherland, I (ed.), Health Education: Perspectives and Choices. George Allen and Unwin.

SUTHERLAND, I (1987). Health Education: Half a Policy. The Rise and Fall of the Health Education Council. National Extension College.

TANNAHILL, A (1984). Health promotion- caring concern. Journal of Medical Ethics, **10**, 196-198.

TANNAHILL, A (1985). What is health promotion? Health Education Journal, **44**, 4, 167-168.

THORNTON, S (1996). Leader of the pack. Health Service Journal, 12 September, 28- 29.

TIMMINS, N (1996). The Five Giants: A Biography of the Welfare State. Fontana.

TONES, K (1983). Education and health promotion: new direction. Journal of the Institute of Health Education, **21**, 4, 121-131.

TONES, K (1986a). Health education and the ideology of health promotion: a review of alternative approaches. Health Education Research, **1**, 1, 3-12.

TONES, K (1986b). Health promotion- a new panacea? Reprinted in Steel, S (ed.), Working in Health Education, National Extension College.

TONES, K (1990). Why theorise? Ideology in health education. Health Education Journal, **49**, 1, 2-6.

TONES, K (1992). Empowerment and the promotion of health. Journal of the Institute of Health Education, **30**, 4, 133-137.

TONES, K (1993). Changing theory and practice: trends in methods, strategies and settings in health education. Health Education Journal, **52**, 3, 125-139.

TONES, K, TILFORD, S AND ROBINSON, Y (1990). Health Education: Effectiveness and Efficiency. Chapman and Hall.

TONES, K AND TILFORD, S (1994). Health Education: Effectiveness, Efficiency and Equity (second edition). Chapman and Hall.

TOON, P (1998). Health promotion in professional education: undergraduate medical education. Presentation to the Health Education Authority conference, Health Promotion: New Directions in Professional Development, London, 6 March.

TOWNSEND, P, DAVIDSON, N AND WHITEHEAD, M (1988). Inequalities in Health. Penguin.

UNIT FOR THE STUDY OF HEALTH POLICY (1979). Rethinking Community Medicine. Department of Community Medicine, Guy's Hospital Medical School.

URMSON, JO (1967). The interpretation of the moral philosophy of JS Mill. In Foot, P (ed.), Theories of Ethics. Oxford University Press.

VAUGHAN, S (1999). Personal communication: demonstration of medical ethics CAL application. 1 November.

WELSH OFFICE (1998). Better Health- Better Wales. The Welsh Office.

WESTRIN, C-G, NILSTUN, T, SMEDBY, B AND HAGLUND, B (1992). Epidemiology and moral philosophy. Journal of Medical Ethics, **18**, 193-6.

WHITEHEAD, M AND TONES, K (1991). Avoiding the Pitfalls. Health Education Authority.

WIKLER, D (1978). Persuasion and coercion for health: ethical issues in government efforts to change lifestyles. Millbank Memorial Fund Quarterly/ Health and Society, **56**, 3, 303-338.

WIKLER, D (1987). Who should be blamed for being sick? Health Education Quarterly, **14**, 1, 11-25.

WILLIAMS, F (1993). Reflecting. In Shakespeare, P, Atkinson, D and French, S (eds.), Reflecting on Research Practice: Issues in Health and Social Welfare. Open University Press.

WILLIAMS, G (1986). Health promotion- caring concern or slick salesmanship? Reprinted in Steel, S (ed.), Working in Health Education, 423- 430. National Extension College.

WILSON, J (1986). Patients' wants versus patients' interests. Journal of Medical Ethics, **12**, 127-130.

WILSON, M (1975). Health is for People. Darton, Longman and Todd.

WILTON, T (1995). Safe sex, safer publishers. Times Higher Education Supplement. 23 June, 18- 19.

WORLD HEALTH ORGANISATION (1946). Constitution. New York: World Health Organisation.

WORLD HEALTH ORGANISATION (1977). Health for All by the Year 2000. Geneva: World Health Organisation.

WORLD HEALTH ORGANISATION (1978). Alma Ata Declaration. World Health Organisation.

WORLD HEALTH ORGANISATION (1984). Report of the Working Group on Concepts and Principles of Health Promotion. Copenhagen: World Health Organisation.

WORLD HEALTH ORGANISATION (1985). Targets for Health for All. Copenhagen: WHO Regional Office for Europe.

WORLD HEALTH ORGANISATION (1986). Ottawa Charter for Health Promotion. Geneva: World Health Organisation.

WORLD HEALTH ORGANISATION (1988). Adelaide Recommendations on Healthy Public Policy. Adelaide: World Health Organisation.

YEO, M (1993). Towards an ethic of empowerment for health promotion. Health Promotion International, **8**, 3, 225-235.

YOUNG,. H (1990). One of Us. Pan.

YOUNG, I AND WHITEHEAD, M (1993). Back to the future: our social history and its impact on health education. Health Education Journal, **52**, 3, 114-119.

# APPENDIX ONE

## BRIEF FOR THE SOUTH BANK UNIVERSITY PHILOSOPHY AND HEALTH PROMOTION ASSIGNMENT

### Assessment

You must produce a critical report reflecting on the philosophical basis of an ongoing programme in a health promotion establishment (formats other than written reports need to be negotiated with your tutor). You must demonstrate an understanding of:

(a) the issues;

(b) the ethical and philosophical considerations;

(c) a dialectical analysis.

These should be investigated through a series of interviews (eg. with a DHE/ PO, a project worker, a consumer) and autobiographical reflection.

Written elements should be typed (double spaced) and referenced according to the required style (see General Programme Guide- Appendix). The critical report should be no less than 4,000 and no more than 6,000 words in length.

## APPENDIX TWO

## SOUTH BANK UNIVERSITY PHILOSOPHY AND HEALTH PROMOTION UNIT SYLLABUS FOR ACADEMIC YEARS 1995-6 AND 1996-7

**Session A:** Introduction to the Module

This session introduces the key themes of the module, participants to each other and to the module's assessment requirements.

**Session B:** Approaching Philosophy

This session introduces some of the key concerns of philosophy and the nature of its methods and arguments.

**Session C:** The Essential Contestedness of Philosophy and of Health Promotion

This session introduces the idea of the essential contestedness of many of the concepts with which philosophy concerns itself; and relates contestedness to the field of health promotion.

**Session D:** Introduction to Ethics

This session introduces key western moral philosophical theories, particularly deontological and consequentialist theories.

**Session E:** Values, Ideology and the Problem of Knowledge in Health Promotion

This session explores the values and ideologies that underpin health promotion and of those who control or practice it.

**Session F:** Ordering Values and Responding to Difficulties: Possibilities and Problems with Health Care Ethics

This session explores bioethical frameworks for supporting moral decision making in health care.

**Session G:** 'The Public Health' and Health Promotion: Is What We Do Ethically Justifiable?

This session explores ways in which the supposed contribution health promotion makes to improving population health can be used to defend the field in an ethical sense.

**Session H:** Women, Philosophy and Health Promotion

This session considers the contribution made by women to the discipline of philosophy and connects these to philosophical understandings of health promotion.

**Session I:** Autonomy

This session explores the importance of autonomy and the principle of respect for autonomy in the fields of health care and health promotion.

**Session J:** Individualism

This session considers ethical justifications of health promotion based on the proposition that it promotes the health and well- being of individuals.

**Session K:** Codes of Conduct- Help, Hindrance or Irrelevant?

This session explores the value or otherwise of codes of conduct in moral deliberation, specifically looking at the code of conduct for health promotion specialists.

**Session L:** Ethics Workshop

In this session, a workshop format is used to explore ethical dilemmas encountered by participants in their own health promotion practice.

**Session M:** Occupational Philosophy

This session considers the occupational philosophies and values carried by, particularly, health promotion specialists.

**Session N:** Personal Study

This session allows time for personal study and reading related to the Unit, and for assignment preparation.

**Session O:** Summary and Evaluation

In this final session, the Unit is reviewed and evaluated.

## APPENDIX THREE

## LETTER FROM THE RESEARCHER SEEKING PERMISSION TO ANALYSE THE ASSIGNMENTS PRODUCED BY STUDENTS IN COHORTS 1995-6 AND 1996-7

Dear

**RE: SOUTH BANK UNIVERSITY PHILOSOPHY AND HEALTH PROMOTION MODULE**

I am writing to all students on the Philosophy and Health Promotion Unit of the 'add-on' M.Sc. to ask for your help.

You might know that I am currently undertaking postgraduate research (hopefully leading to a Ph.D.) at King's College London. I would value your assistance with my studies.

What I would like to do is to spend some time considering and analysing the critical report you are about to submit. My purpose in doing this is to inform my research by trying to detect 'themes' in philosophical and ethical concerns perceived by those working in health promotion; and to work out how you have responded to these concerns in the context of your involvement in the M.Sc. module. I then hope to link this 'empirical' analysis with the theoretical foundations I have been attempting to build and which I have tried to share with you during the module.

I should make it completely clear that my use of your report will in no way be linked to the assessment process for the module. This is an independent exercise for my own research benefit. Additionally, I will treat any access you allow me to your report as confidential; no views expressed or cases described will be attributed to anyone without their express permission, which I will specifically seek if I think attribution is required ( I should say that at the moment I think this will be unlikely). It may be that at some point I would like to seek your further views on the subject you have written about and I would be grateful for your permission to do so if necessary.

Pam Schickler as Course Director is happy for me to make this request to you.

I would be very grateful if you could complete the attached form and return it to me in the stamped addressed envelope provided to let me know that you would be happy to agree to my request. It would help me greatly if you were able to do this before the

end of January. If you need any more information, or would like to discuss my request, I would be very pleased to hear from you.

I do hope you will feel able to help me in this way with my research and look forward to hearing from you.

Thank you in anticipation for your help.

Yours sincerely

**Peter Duncan**